



Critical Care Nurses' professional identity  
constructions in an Australian Intensive  
Care Unit:  
Contextual and Contingent

by

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## Declaration of Originality

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Melissa-Jane Belle

4<sup>th</sup> July 2017

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# ABSTRACT

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Professional identity is a social identity that is informed by the experience of being a member of a professional group and undertaking work activities within a specific professional jurisdiction. Despite a dominant ideology of professionalism within university based nursing degrees, in practice, professional identity among nurses is often marked by ambiguity and a lack of clarity. Some writers have described a disconnection between the ideology of professionalism that informs nursing's professional identity, and the experience of nursing practice. This thesis uses a social constructionist approach and ethnographic methods to explore professional identity among Critical Care Nurses (CCNs). The research aimed to build an in-depth understanding of the ways that CCNs, as specialty nurses, construct their professional identity in the context of their practice. The research was conducted in a single Intensive Care Unit (ICU) in Tasmania, Australia over a six-month period. The data was collected from participant observation of 13 CCNs as they went about their work and semi-structured interviews with 8 CCNs. The fieldnotes and interview transcripts were analysed using a process of thematic analysis.

The analysis found that CCNs actively construct their professional identity through subjective meaning making and multidimensional processes of similarity and difference (boundary work) within and across dynamic professional boundaries. CCNs were found to attach meanings to particular actions, symbols, rituals and utilisation of artefacts to construct their professional identity. These were then used to negotiate boundaries of difference between themselves and other nurses as well as other health professions. The analysis also revealed that CCNs' experiences of

professional identity are complex and contingent due to the influence of structural and organisational forces that shape and constrain their meaning making during everyday work interactions.

These findings provide new theoretical and empirical knowledge about the ambiguity of professional identity and its contextual construction at inter- and intra-professional levels. They also show that for CCNs, professional identity is actively constructed through interactions and practice. This contributes to a more insightful understanding of the subjectivity of CCNs' professional identities within the context of ICUs, and thus, not only offers the basis for comparative studies of professional identity between nursing specialties, but also between nursing and other health care professions/occupations. The thesis findings also suggest that there is incongruence between nursing's ideology of professionalism and the structure of employing organisations that do not always acknowledge or support postgraduate nursing qualifications or the development of advanced nursing practice roles. A strong sense of professional identity appears to increase worker satisfaction and contributes to the capacity of professional groups to achieve improved working conditions. As such, barriers to the development of professional identity among CCNs have implications for the lived experiences and may help explain high levels of worker turnover in this nursing speciality.

# CHAPTER ONE

## INTRODUCTION

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Professional identity is a significant aspect of any profession (Secrest, Norwood and Keatley 2003). Nurses are presumed to be socialised into a professional identity during their nursing education and training. In reality, however, the professionalisation of nursing has reshaped its practice and roles in a manner that has made its professional identity highly elusive. Thus, the professional identity of nurses is complex and 'contested' (Crawford, Brown and Majomi 2008:1056; Jebril 2008; Johnson et al. 2012; Willetts and Clarke 2014).

In this thesis I present findings from an ethnographic study of the meanings that Critical Care Nurses (CCNs) attach to their professional identities, and how these are constructed amid the ambiguity of the CCN role. I argue that the ambiguity of nursing's professional identity arises from a discrepancy between the ideology of professionalism into which student nurses are socialised and nurses' own experiences of this in the course of their everyday practice. The findings offer new empirical knowledge of the salient aspects of CCNs' professional identities from within the specific practice context of an Intensive Care Unit (ICU) that

can contribute to theorisations of nursing's professional identity more broadly.

### **Professional identity**

In this thesis, professional identity is conceptualised as an individual and collective social identity informed by the subjective experience of being a nurse and a professional. It arises from being part of a professional group and internalising common 'knowledges, behaviours, skills, attitudes, values, role and norms' that are appropriate to a specific profession (Fagermoen 1997; Mooney 2007; Öhlén and Segesten 1998: 722).

Professional identity involves constructing differences between knowledges and practices of professionals during interactions in everyday workplace settings. From this, professional identity emerges as relational; it is constructed, performed and reproduced in relation to differences of other professions and serves to delineate the boundaries between professional groups (Abbott 1988; Hughes 1971; Nancarrow and Borthwick 2005).

There are competing theories of professionalisation and professionalism and these result in quite different understandings of professional identity.

Within the discipline of nursing, professionalism is theoretically informed by the trait approach to professions. This explains professionalism as a gradual attainment of traits that are identified as traditionally distinguishing professions from occupations (Greenwood 1957; Wilensky 1964). From this perspective, nursing is viewed as having completed a professionalising process to achieve professional status (Larson 1977; Willetts and Clarke 2014). A key aspect of nursing's disciplinary claims is that practice is underpinned by distinct disciplinary knowledge, namely the holistic or patient centred approach to health provision (Allen 2014; Oldnall 1995).

While trait approaches represent a significant historic development in sociological understandings of professions, many sociologists take a critical view of the claim that a professionalising process and the adoption of profession-like traits will result in nursing achieving professional status (Etzioni 1969; Freidson 1970a; 1970b; Willis 1989). Trait approaches in general are viewed as problematic by sociologists because they locate professional identity in an objectively based structuralist framework, and thus it represents an ideal type that is disconnected from the realities of nurses' everyday practice (Dingwall 2008; Willetts and Clarke 2014). In contrast, action-based sociological understandings emphasise the subjective, dynamic and political nature of professional identity (Abbott



1988; Becker et al. 1961; Freidson 1970a; 1970b; Hughes 1971; Larson 1977; 1980).

Empirical work on professional identity of nurses working in specialty areas has included midwives, mental health, and community health nurses (Caldas Nicacio et al. 2016; Crawford, Brown and Majomi 2008; Drew 2011; Hurley and Lakeman 2011; Larsson, Aldegarmann and Aarts 2009). This shows that nurses employed in specialty areas share values, beliefs and work activities that are distinct to the context and practice of their specialty roles, rather than those of nursing more broadly (Fitzgerald and Teal 2004; Lok, Rhodes and Westwood 2011; Mallidou et al. 2011). Yet, this work is underpinned by assumptions of nursing's professionalism, and thus, it has problematized the simple story that nursing is a profession now. Moreover, the lack of social constructionist research on CCNs' professional identity demonstrates the necessity of empirical work focusing on this topic.

### **Critical Care Nurses**

CCNs are Registered Nurses who, according to the International Council of Nursing (2008), practise autonomously and collaboratively within the acute hospital setting. CCNs have been selected as an example of a nurse

specialty group due to the acute nature of their practice. This is characterised by delivery of high levels of care that are mediated by ever increasing technology and the dominance of a biomedical perspective (Almerud et al. 2008b). These features stand in opposition to the holistic or patient centred approach to health provision that underpins nursing's claim to professional status, and therefore make the CCN role distinctive and specialised. Moreover, the establishment, expansion and extension of the CCN role have contributed to a 'blurring' of the jurisdictional boundaries of professionalism between nursing and other health professions, including medicine (Nancarrow and Borthwick 2005; Tye and Ross 2000:1098).

CCNs' practice, inside the 'technologically intense' (Almerud et al. 2008a) and multidisciplinary settings of ICUs, focuses on the provision of care for critically ill patients, and support to patient's family members (Almerud et al. 2008b; Carmel 2006b). In addition, CCN practice encompasses the application, management and interpretation of technical diagnostic and treatment interventions (AIHW 2012a; Edwards, Throndon and Girardin 2012: 35; Rose 2011). CCNs' focus on critically ill patients and emphasis of technology characterises their practice as highly prestigious within a health system that prioritises acute nursing practice (Smith and Allan

2016; Zadoroznyj 1998). Yet the CCN role and practice are confounded by a lack of clarity in the nursing role more broadly

(Currie and Carr - Hill 2013; Hewitt-Taylor 2003) and the non-standardisation of particular nursing roles in International and local contexts (Coombs, Chaboyer and Sole 2007; Gardner 2010; Gardner et al. 2017; Iliopoulou and While 2010; Tye and Ross 2000). This confusion is exemplified within the Australian health system where specialty nursing roles have developed under different circumstances across State, rather than National, levels (Baldwin et al. 2013; Elsom and Happell 2006).

Within this thesis, CCNs are distinguished from “Nurse Specialist” or “Advanced Practice Nurse” roles, such as Clinical Nurse Specialist (CNS), Clinical Nurse Consultant (CNC) and Nurse Practitioner (NP), established within the Royal College of Nursing Australia (RCNA)(2006). This is notable because, while many of the CCNs participating in the study hold the postgraduate accreditation to qualify for such advanced nursing roles; these are not clearly demarcated employment titles common to the selected field site. This is despite CCNs engaging in ‘a level of nursing practice that utilises extended and expanded skills, experience and knowledge in assessment, diagnosis, planning, implementation and evaluation of the care required’ that corresponds to the definitions of

advanced nursing roles set down by the Royal College of Nursing Australia (RCNA 2006).

CCN practice is predominately focused on the body, or physical aspects of often unconscious patients, and this sits in opposition to the holistic, or patient centred, approach to health provision that is a distinct and central element in the identity of the nursing profession (Allen 2014; Almerud et al. 2008a; Wilkin and Slevin 2004). As such, it is of interest to explore if, and how the distinctiveness of CCNs' role and practice may inform their professional identity. Moreover, an exploration of CCNs' construction and negotiation of professional identity offers an opportunity to investigate how they integrate nursing ideals of holism into a practice role in which technology is a central feature (Almerud et al. 2008b). Understanding this process of incorporation would reveal how CCNs overcome the ambiguity of their practice role to construct professional identity, and this will contribute to theoretical and empirical knowledge and debates of professional identity within nursing.

### **Justification for the study**

Nursing's professional identity requires exploration in order to gain insight into its nature and strength. A strong professional identity is

associated with a range of positive outcomes for members of a profession because it enables the interests of group to be maximised through advice provision, lobbying and credentialing (Evetts 1999:122). There are empirical associations between a lack of clarity surrounding professional identity and increased levels of work dissatisfaction and lowered retention rates (Brennan 2009; Lavoie-Tremblay et al. 2008). When applied to nursing, the strength of its professional identity also shapes working conditions and, by extension, the quality of care provision to patients (clients).

It does appear that nursing is negatively impacted by a lack of clarity about professional identity. Internationally, nurses are identified as the most dissatisfied group of professionals within the health care system and this is partly due to the ambiguity of the contemporary nursing role that informs professional identity (Aiken et al. 2001; O'Brien-Pallas et al. 2010).

The World Health Organisation (WHO) (2007) reports a shortage of registered nurses in more than half its member countries. In Tasmania, there were an estimated 7,041 persons employed as registered nurses in 2011. This represents a decrease of 1.7% in supply from 2007, and this decline seems set to continue (Australian Institute for Health and Wellbeing (AIHW) (2012b: 10). Current projections suggest further

reductions in the numbers due to an ageing population within the profession, with statistics indicating the proportion over 50 years has increased from 33.0% to 38.6% from 2007- 2011(AIHW 2012b: 15, 24, 25).

This thesis responds to the ambiguity of nursing's professional identity, both generally and within particular nursing specialties (Crawford, Brown and Majomi 2008; Hercelinskyj et al. 2014; Sayers et al. 2015). This study replies to the discipline of nursing's calls for research focused on the ways that practitioners' own social contexts can influence professional identity and of how diverse practice environments shape their constructions (Fitzgerald and Teal 2004; Hensel 2014; Lok, Rhodes and Westwood 2011; Mallidou et al. 2011; Willetts and Clarke 2014).

### **Aims and research questions**

Within the context of debate about nursing's claim to professionalism and the lack of clarity of its professional identity, this study is focused on the perceptions of CCNs working in the distinct environment of an ICU. I represent CCNs' professional identities in the plural to emphasise the diversity and nuance of their subjective experiences as nurses and professionals. My central aim is to explore, describe and interpret the meanings attached to their professional identities, and how these are

constructed amid the ambiguity of the CCN role. To achieve this, an ethnographic focus is placed on CCNs' shared meanings, work activities, and interactions in their workplace. Of central importance is how CCNs attach specific meanings to their actions, language, rituals and utilisation of artefacts, and how these meanings are applied to negotiate professional boundaries between themselves and other health professionals.

As a result of these considerations, the research questions guiding this thesis are:

- How are Critical Care Nurses (CCNs) constructing their professional identities from within the context of their practice area?
- What are the meanings that Critical Care Nurses attach to the actions, language, rituals and utilisation of artefacts that inform their professional identities in everyday practice?
- How are Critical Care Nurses utilising the meanings they attach to professional identity to negotiate practice boundaries with other health professionals?

To answer these questions, data were generated through participant observation and semi-structured in-depth interviews with currently

registered CCNs practising within a single ICU overseen by the Department of Health and Human Services Tasmania. The approach and its justification will be explained further in Chapter Three, 'Methodology and Method'.

Within the context of the sociological contestation of nursing's claim to professionalism and the lack of clarity of its professional identity, this study is informed by the perceptions of CCNs working in the distinct environment of an ICU. I represent CCNs' professional identities in the plural to emphasise the diversity and nuance of their subjective experiences as nurses and professionals. My central aim is to explore, describe and interpret the meanings they attach to their professional identities, and how these are constructed amid the ambiguity of the CCN role. To achieve this, an ethnographic focus is placed on their shared meanings, work activities, and interactions in their workplace. Of central importance is how CCNs' attach specific meanings to their actions, language, rituals and utilisation of artefacts, and how these are applied to negotiate professional boundaries between themselves and other health professionals.



The existing research on CCNs, however, does not include professional identity as a central focus, but rather, inter-professional collaboration, CCNs' decision making, group cohesion, and the provision of holistic care within a highly technological specialty nursing area (Baggs and Ryan 1990; Bucknall 2003; Carmel 2006a; Chaboyer and Patterson 2001; Manias and Street 2000; Manias and Street 2001b). This study responds to such limitations by contributing to increasing knowledge of the professional identity of CCNs.

The central argument of this thesis is that the ambiguity of nursing's professional identity arises from a discrepancy between the ideology of professionalism into which student nurses are socialised and nurses' own experiences of this in the course of their everyday practice. The findings offer new empirical knowledge of the salient aspects of CCNs' professional identities from within the specific practice context of an Intensive Care Unit (ICU) that can contribute to theorisations of nursing's professional identity more broadly.

## **Chapter Outline**

The following Chapter, 'Professions, Professionalism and Professional Identity' is a review of theoretical literature and empirical evidence to

provide insight into the meanings that underpin CCNs' professional identities. It additionally establishes professional identity is a complex social process involving interactions at macro, meso and micro levels, and demonstrates an empirical gap in the literature on the topic of CCNs' professional identities. A brief history of nursing's professionalisation and the development of the CCN nursing role are first presented. This is followed by a critical discussion of research on professional identity through three perspectives: personal understandings, ideological constructions, and the professional nursing role, which advance an interactionist understanding as providing the most benefit to extending knowledge on the topic. The chapter additionally introduces the concept of boundary work, and its importance in the construction of professional identity at the individual, organisational and institutional levels. Finally, the tensions between the ideological construction of nursing's professional identity and its experience in the context of everyday practice are considered.

In Chapter Three, 'Methodology and Methods' I detail the epistemology and ontology underpinning the ethnographic methodology adopted for this study, as well as the accompanying methods of participant observation and semi-structured in-depth interviews. The procedure of

the study is explained, and advantages and disadvantages of my position in 'the space between' (Dwyer and Buckle 2009) are detailed. The choice of methodology is justified on the basis of its ability to capture 'thick descriptions' (Geertz 1973: 5) of CCNs 'learned patterns of values, behaviours, beliefs and language' (Harris 1969 in Creswell 2013: 90). The chapter also details the importance of my own reflexivity in acknowledging and managing challenges within the field.

In Chapters Four, Five, Six, Seven and Eight the findings of the study are presented. Chapter Four, 'Multiple Constructions of Professional Identities' problematises professional identity by exploring the contention and contradictions of CCNs' meanings. It explores CCNs' nuanced perceptions of professional identity through the presentation of four themes: the challenge of definition, professional identity as a subjective experience, professional identity informed by the professionalism of nursing, and professional identity informed by the professional role, to argue CCNs' subjective understandings of their professional identities contribute to its ambiguity. The chapter additionally introduces participants' valuing of particular forms of nursing knowledges, and how these are integral to the processes of difference that underpin professional identity.

In Chapter Five, 'The Centrality of Knowledges', CCNs' nursing knowledges become the focus of analysis, as these are shown to be fundamental to their shared meanings of practice. I use the word knowledges in the plural deliberately to emphasise the various aspects of nursing knowledge that are employed in CCNs' everyday practice, and to indicate that nursing knowledges are one of a number of knowledges positioned within a hierarchy in the ICU. The chapter further explores CCNs' valuing of distinct forms of knowledges that informs their professional identities through five subthemes: theoretical knowledge, clinical knowledge, technical knowledge, tacit knowledge, and legislative, ethical and procedural knowledges. In discussing these, the importance of specific knowledges in professional identity, hinted to in Chapter Four, is extended to illustrate CCNs' demarcation of professional boundaries between themselves and other health workers.

Chapter Six, 'CCNs' Inter-professional Interactions' moves to analyse how CCNs draw on specific meanings and value of their knowledges within their interactions with other health professionals. This demonstrates how CCNs employ their expert knowledges to negotiate professional boundaries within other health workers through processes of inclusion

and exclusion. More importantly, the chapter reveals CCNs' inter-professional interactions are shaped by structural and organisational factors external to nursing. These contingently and continually reshape the professional boundaries of participants' practice, and in responding to their shifting, the practice role that informs CCNs' professional identities becomes unclear.

The themes of Chapter Six continue in Chapter Seven 'CCNs' Intra-professional Interactions' where analysis shifts to interactions between CCNs. This chapter draws on four examples; the preparation of medication, acute events, meal breaks and temporal boundary work to illustrate the salience of processes of difference in CCNs' professional identities. These examples reveal the tensions between the ideal of autonomous practice promoted by the professionalism of nursing, and the collaborative environment of the ICU. Further, the implications of CCNs' conflicting constructions, and the influence of medical dominance on professional identity are considered.

In the final findings chapter, Chapter Eight 'Professional Development Mismatch', the importance of education and extension of knowledge within CCNs' professional identities is made further evident. I present

three themes; nursing's professionalism, learning and supporting of staff, and role performance and promotion, to expand on the importance of CCNs' intra-professional boundary work. Intra-professional processes of difference reveal tensions between CCNs that arise from a lack of standardisation of employment levels, and promotional criteria within the ICU and the hospital generally. This is significant, as it demonstrates an incongruence between the professionalism of nursing and organisational and institutional recognition.

The concluding chapter, 'Overcoming Ambiguity?' draws on significant aspects from the previous five chapters to answer the research questions, and discuss the implications of the findings for the literature, individual nurses, and the nursing profession. I raise questions of the strength of CCNs' professional identities as a single nursing specialty group, and what this means for nursing more broadly. I suggest that the ambiguity of nursing's professional identity has not been overcome in this study, but rather the influences that contribute to a lack of clarity have been identified, and this opens opportunities for future research directions.

## CHAPTER TWO

# Professions, Professionalism and Professional Identity

---

### **Introduction**

The professional identity of nursing is of current research interest in both Australian and international contexts. Much of this research has arisen in response to the reshaping of the nursing role and identity associated with not only the group's professionalisation, but also organisational, economic and technological changes of the 21<sup>st</sup> Century. In this chapter, I review theoretical literature and empirical evidence on professions, professionalism and professional identity to provide background on the current body of work on the professional identity of nursing. More specifically, I draw attention to a significant empirical gap on the topic of CCNs' professional identities in both Australian and International contexts. In not examining this topic, the ambiguity surrounding nursing's professional identity has the potential to contribute to ongoing issues of worker dissatisfaction and lowered retention rates.

The chapter moreover establishes that the professional identity of nursing is a complex social process involving interactions at macro, meso and micro levels. The concept of boundary work and its importance to empirical work on professional identity at the individual, organisational and institutional levels are introduced. This is important to provide context to the thesis by demonstrating that the professionalism of nursing, and its professional identity are shaped by social, organisational and political forces external to the profession, and these have a major influence on CCNs' subjective experiences in everyday practice.

The chapter begins with an overview of the historic development of both nursing as a profession and the CCN role in the Australian context. I then evaluate empirical work on the professional identity of nursing by exploring three different, but interrelated perspectives: personal understandings, ideological constructions, and the professional nursing role. In so doing, I incorporate contemporary debates and challenges surrounding the professionalism that informs nursing's professional identity, and emphasise the tensions between the ideological construction of nursing's professional identity, and its experience in the context of everyday practice are considered.



## **The professionalisation of Australian nursing**

Nursing has a long history; the sick and infirmed have always needed care and historically, this was provided by family members and charitable organisations. The arrival of five religious nurses of the Catholic Sisters of Charity in 1838 and Nightingale-trained nurses, under the supervision of Lucy Osborn to New South Wales in 1868, marked the official beginning of Australian nursing history (Godden and Helmstadter 2004; Lumby and Osmond 2006; Nelson and Greehan 2006). Historically, nursing was 'women's work', and thus, a low status occupation (Smith and Allan 2016:73; Zadoroznyj 1998). Work was tedious, remuneration was low and the majority of young women entering nursing were acquired from the lower classes. Nurses were expected to be obedient to senior nurses, and all were subordinated to the direction of the medical profession (Jasmine 2009; Lundmark 2007). Nursing training was located within the hospital setting in an apprentice-style system and governed by the needs of the medical practitioners. Nursing was ritualised and task based; training fostered instrumental skills as opposed to providing a theoretical basis for task performance (Graham 2010; Nelson and Greehan 2006).

The questionable working conditions, the emphasis on discipline, and the requirement for nurses to live on-site during training, facilitated the

development of solidarity among nurses (Brennan and Timmins 2012; Keleher 2014). This sense of unity supported the development of a collective nursing culture; a learned system of shared beliefs, attitudes, values and expectations about appropriate ways to behave in certain situations (Madsen et al. 2009). This informed their identity as nurses, which traditionally included the acceptance of the medical profession's control over nurses (Nelson and Greehan 2006; Water et al. 2016).

The early movement of Australian nursing from an occupation controlled by the medical profession to an established profession in its own right can be traced to the turn of the 20<sup>th</sup> Century (Keleher 2014; Zadoroznyj 1998). In Australia, this is evident in the initial formation of voluntary nurses' registration boards, such as the Australian Trained Nurses Association (in New South Wales) in 1899 and the Victorian Trained Nurses Association (VTNA) in 1902 (Keleher 2014; Lumby and Osmond 2006; Nelson and Greehan 2006). These organisations regulated nursing practice through the formal registration of trained nurses, thus excluding untrained workers from practising nursing. Yet, these State-based regulatory bodies were not given political recognition until the early 20<sup>th</sup> Century (Keleher 2014; Lumby and Osmond 2006).

State-based nursing organisation played a crucial role in providing momentum towards the attainment of professional status, particularly after the release of The World Health Organisation's Chittick Report (1968). This report called for urgent reforms to nursing, including introduction of more acceptable working conditions and higher remuneration. In response, nursing leaders, State-based nursing organisations and nursing unions collectively lobbied for political change. Their endeavours, however were frequently constrained by the male domination of the medical profession and hospital administration (Kanisaki and Johnson 2002; Keleher 2014).

During the 1970s, and into the 1980s, nurses became further resistant to subordination to the medical profession, and their less than ideal working conditions. They continued to collectively lobby for control of nursing education, training, management and working conditions, and became increasingly more 'militant' (Zadoroznyj 1998:20). By the mid-1980s, nurses had taken industrial action in four Australian States and one Territory, culminating in the six week Victorian State Nurses' strike of 1985-86 (Willis 2004). Advanced professionalisation followed and nursing looked to achieve professional status by emulating the professional characteristics of medicine. This included arguing nursing knowledge and

practice as separate from the medical profession, and thus, establishing a 'professional claim' (Andrew 2012; Hughes 1963:656; Willis and Parish 1997).

The argument of nursing's expert knowledge as unique to the specialty practice of care provision was central to moving out from under the shadow of medicine (Wilkinson and Miers 1999). The knowledge and practice of nursing is distinguished from that of medicine; medicine's focus is curative, whereas nurse's focus on the provision of holistic care, thus not initially legitimised by medicine (Johnson 1961; Nightingale 1969; Treiber and Jones 2015). The holistic care of nursing involves building 'therapeutic relationships' with patients and considering beyond the purely corporeal view of medicine to encompass 'the whole person', that is, the psychological, social and cultural aspects of individual's lived experiences (Allen 2014:131).

State recognition of nursing as both scientific and distinct from medicine was a central movement for nursing's professionalisation, and this was heralded by the Australian Federal Labor Government's Minister for Health, Dr. Neal Blewett (1984). From this, Australian nursing training

rapidly transitioned to tertiary education institutions, and this was a catalyst for the introduction of an evidence- based, as opposed to traditional task-based approach to practice (Kanisaki and Johnson 2002). Control of nursing knowledge enabled development and on-going expansion and extension of specialty nursing roles and accompanying postgraduate education for nurses, including the establishment of nursing institutions, such as the Australian College of Nursing (previously Royal College of Nursing Australia) (Keleher 2014).

Since mid-1980s, the professionalism of nursing has developed and evaluated tertiary nursing education curricula (Coombs, Chaboyer and Sole 2007; Grealish and Smale 2011), improved working conditions, and increased remuneration for nurses (Zadoroznyj 1998). These evolutions have accompanied the expansion (widening within the limits of nursing education, theory and practice), and extension (widening outside the limits of nursing into the practice of other health professionals) of the traditional nurse's role (Carver 1998; Magennis, Slevin and Cunningham 1999). While this reshaping is argued to result from increased levels of nursing education, an alternative account suggests it emerges from shortages of medical staff (Coombs, Chaboyer and Sole 2007). Whichever the reasoning, the professionalism of nursing signalled the introduction

and advancement of postgraduate education courses which encompass a widening array of nursing specialties, as well as the creation of specialist, or advanced nursing roles (Appel, Malcolm and Nahas 1996; Ross, Barr and Stevens 2013; Sheer and Wong 2008). These courses sit in conjunction with the recently introduced necessity of continuing professional development for Australian nurses so as to maintain currency and continuation of registration (Ross, Barr and Stevens 2013).

### **Critical Care Nurses**

Critical Care Nurses (CCNs), also known as Intensive Care Nurses (ICNs), are registered nurses practising within Critical Care, or Intensive Care Units (ICUs). Their specialty is providing holistic nursing care to patients experiencing complex acute and critical medical conditions, such as traumatic injuries or multi-system failure (Harris and Chaboyer 2002). CCN practice is distinctive compared to general medical or surgical nursing as the role involves strong adherence to the biomedical perspective of health and illness, and high reliance on technology in patient assessment and medical intervention (Almerud et al. 2008a). These features stand in opposition to the holistic, or patient centred approach to health provision underpinning nursing's claim to professional status and therefore, the CCN role is distinctive and specialised.

The role of CCNs in Australia emerged from the development of ICUs during the late 1960s and early 1970s (Coghlan 1986). Although the role was initially dictated by the needs of senior hospital-based medical staff, the acute conditions of patients and utilisation of developing technology within ICUs meant that CCNs scope of practice was extended and expanded in relation to other nurses (Coghlan 1986). Professionalisation saw control of postgraduate courses into the hands of nursing at such institutions as the Royal College of Nursing Australia (formally the College of Australian Nursing) and establishment of colleges delivering specialty nurse education, including the Australian College of Critical Care Nursing. The CCN role has since expanded to include the activities of venous cannulation, autonomous management of renal dialysis and sedation levels of ventilated patients, practices previously controlled by the medical profession (Harris and Chaboyer 2002; Pearcey 2008; Quinn and Thompson 1999).

The 'unique' nature of CCN practice means widening empirical interest in the nursing speciality particularly. Further CCN practice has provided a basis for comparative studies of nurses practising in other areas (Briggs 1991:223). Qualitative research of novice CCNs revealed their concerns around their knowledge, skills and accountability, as well as their ability

to time- manage and socialise into the distinctive environment of the ICU (Farnell and Dawson 2006; O'Kane 2012). Despite these findings, CCNs were found to move progressively from 'novice to expert' as they incorporate intuitive knowledge into their practice (Benner 1982; 1992; Benner and Tanner 1987).

CCN practice is characterised by the provision of holistic care within a highly technological environment. Literature reviews and historical analyses are foundational to on-going philosophical debates of the '(ir)reconcilable differences' between care and technology, which are central to CCNs' 'life-worlds' (Barnard and Sandelowski 2001; Sandelowski 1997; Walters 1995). Phenomenological approaches to understanding the dichotomy between care and technology have emphasised the importance of both 'technological competence', and CCNs' necessity to balance objective technological aspects with subjective experiences of patients to deliver holistic care (Almerud et al. 2008a; 2008b; Little 1999; 2000).

Given the assumed or actual contrast between technology and care in the ICU, the context of CCNs' practice is central to empirical research. Cross



cultural studies of CCNs indicate direct patient care, including hygiene, delivery of medication, patient assessment and observation to be primary work activities of practice (Harrison and Nixon 2002; Kaya et al. 2011). An issue identified in CCN practice is delivery of care in an environment where patients are generally unconscious (Almerud et al. 2008a; 2008b). In response, reviews of nursing literature and qualitative research suggest, in such situations, CCNs' mediation between technology, the patient and patient's families, as well as providing support exemplifies provision of holistic care (Holden, Harrison and Johnson 2002; Sandelowski 1997).

Aside from the technological focus, the ICU is also distinguished from other areas of nursing practice by its characteristic inter-professional collaboration (Chaboyer and Patterson 2001; Rose 2011). Focus group and literature reviews have defined collaboration as a process of power sharing involving exchange and trade of resources between interdependent partnerships (D'Amour et al. 2005; Lingard et al. 2004; Rose 2011). Studies of CCNs' collaboration with medical staff have generally generated contradictory results. While quantitative approaches in Australia found CCNs perceive higher levels of collaboration with doctors, compared to generalist nurses (Chaboyer and Patterson 2001; Chaboyer, Najman and Dunn 2001b). In contrast, Reader et al.'s (2007)

British study indicated incongruence between CCNs and doctors' perceptions of collaboration; although senior doctors perceived high levels of collaboration with CCNs, nurses' perceptions of doctors' collaboration were considerably lower. Literature reviews have additionally emphasised inter-professional collaboration is contextual, as it is shaped by not only interpersonal determinants at the micro level, but also meso and macro influences, such as internal organisational restrictions, and systemic forces external to the workplace (San Martín-Rodríguez et al. 2005).

In the collaborative environment of ICUs, nurse-doctor interactions have been a principal research focus, particularly in efforts to understand interprofessional collaboration. Much of this work found power differentials between doctors and nurses' interactions were weighed in favour of the former. Ethnographies of Australian and British ICUs found the privileging of biomedical knowledge means CCNs' input is usually only to supplement and augment doctors' knowledge, and thus, nurses are generally marginalised and 'pushed to the periphery' during decision making processes (Coombs 2003; Hill 2003:234; Manias and Street 2001b). However, empirical evidence indicates CCNs do resist medical dominance by asserting themselves during interactions with doctors. This includes CCNs' acknowledging the importance of their contribution to decision-

making around patient management, and engaging in strategies of inclusion, such as 'being there, knowing the script, knowing what (they) want from the ward round, and silencing the (medical) gaze, and thus 'break through the inner circle of medicine' to exercise autonomy (Bucknall 2003; Coombs 2003:131; Hill 2003:233).

Positive correlations between CCNs' inter-professional collaboration, autonomy and job satisfaction have been shown in International and Australian studies of ICUs (Chaboyer, Najman and Dunn 2001b; Iliopoulou and While 2010; Varjus, Suominen and Leino-Kilpi 2003). CCNs generally perceive a high degree of autonomy in their work, although this finding differs across contexts. For example, while CCNs in Australia identify lower levels of autonomy than generalist nurses, International studies show significant statistical differences in autonomy between senior female, male and junior CCNs (Chaboyer, Najman and Dunn 2001b; Iliopoulou and While 2010; Varjus, Suominen and Leino-Kilpi 2003).

While the ICU is characterised by collaboration, research also revealed it as an environment of conflict. Australian studies of inter-professional

collaboration from a negotiated order perspective identify conflict arises from the exercise of two, opposing forms of power; 'competitive power and collaborative power' (Nugus et al. 2010:902,907). Canadian statistical studies show an estimated 50% of CCNs reported instances of conflict over patient management occurring within the previous seven days, with 35% of instances involving team members (Edwards, Thronson and Girardin 2012:15).

Conflict is a significant issue between CCNs as statistics from International and National investigations demonstrate horizontal violence is not only common to nursing more broadly, but it is more concentrated within ICUs than other areas of nursing (Randle 2003a; Vessey et al. 2009). Horizontal violence, sometimes referred to as lateral violence or workplace bullying within nursing literature, is defined by Randle (2003a:399) as:

*Repeated, offensive, abusive, intimidating, or insulting behaviours; abuse of power; or unfair sanctions that make recipients feel humiliated, vulnerable, or threatened, thus... undermining their self-confidence.*

Farrell (2001) identified conflict between nurses arises from issues at three levels. These include conflict between nurses and dominant groups, such as cliques, conflict arising from the organisational environment, and interpersonal tensions. An Australian survey found interpersonal conflict,,

rather than organisational forces, contributed to CCNs and generalist nurses' perceptions of weaker workplace cohesion than previous British research (Chaboyer, Najman and Dunn 2001a).

Research about ICUs and CCNs has been wide-ranging and beneficial to gaining insight to the distinct practice area in Australian and international contexts. While there have been a number of micro-level studies focusing on CCNs practice, the topic of professional identity and the meanings attached to it by this group of nurses remains largely unexplored.

Moreover, while CCNs and doctors' interactions have been the centre of Australian qualitative work, the contribution of these exchanges to professional identity construction has not fully been explored. This represents a significant gap in empirical knowledge of the meanings CCNs attach to their professional identities, and how it is performed in everyday practice. As such, it is important to yield empirical knowledge on this topic which can address the ambiguity of nursing's professional identity and its negative implications.

### **Professional identity**

The importance of professional identity is the benefits it offers not only to its members, but also for their clients and employing organisations. A

strong professional identity contributes to increased productivity levels, and thus, efficiency within employing organisations (Johnson et al. 2012). Empirically, its strength has been shown to increase worker satisfaction and retention rates, and decrease levels of staff burnout (Cowin et al. 2008; Sabanciogullari and Dogan 2015; Sharbaugh 2009). Moreover, a solid professional identity is considered important for professional recognition and the achievement of collective professional goals, the securing of more agreeable working conditions, higher allocation of work resources, and higher remuneration (Abbott 1988; Freidson 1970a; 1970b; Hughes 1971). These can enable a higher quality provision of services to professions' clients (Evetts 1999; Takase, Maude and Manias 2006), which in the case of nursing should translate to a higher quality of holistic care (Aiken et al. 2001).

Nursing, psychological and sociological literature share the commonality of professional identity being ambiguous and complex (Jebril 2008; Johnson et al. 2012; Willetts and Clarke 2014). Despite lack of theoretical or conceptual consensus, theorists from these disciplines agree the professional identity of nursing is an awareness and experience of being a nurse or professional (Arthur and Randle 2007; Jebril 2008; Johnson et al. 2012; Öhlén and Segesten 1998; Snelgrove 2009). There are, however,

distinct differences in the theoretical underpinnings of this understanding, and three conceptual associations can be made. These are:

- Personal understandings: Self-image, self- concept, professional self-concept, self-identity and nursing identity (Arthur and Randle 2007; Brennan and Timmins 2012; Cowin and Hengstberger-Sims 2006; Fagerberg and Kihlgren 2001; Hoeve, Jansen and Roodbol 2013; Piil et al. 2012; Sasaki and Hariu 2006);
- Ideological Constructions: Professions and professionalism (Allen 2007; Kim-Godwin, Baek and Wynd 2010; Secrest, Norwood and Keatley 2003);
- Professional identity: The professional or nursing role (Baldwin 2012; Brennan 2009; Currie, Finn and Martin 2010; Gregg and Magilvy 2001; Hughes, Hughes and Deutscher 1958; Hughes 1958; Hughes 1971; Larsson, Aldegarmann and Aarts 2009; McCrae, Askey-Jones and Laker 2014).

Connections between professional identity, self-concept, professional self-concept and nursing identity, focus on how individuals understand themselves as a nurse and professional from a personal perspective (Arthur and Randle 2007; Öhlén and Segesten 1998). These are distinguished from professions and professionalism, which refer to

nursing's ideological construction (Hughes 1963; Hughes, Hughes and Deutscher 1958; Willetts and Clarke 2014), and professional identity as constructed on the performance of the role of nurses (Currie, Finn and Martin 2010; Fagermoen 1997; Larsson, Aldegarmann and Aarts 2009). While this thesis identifies the three themes mentioned above, in practice they are not separate, as professional identity is comprised of personal, inter-personal and socio-historic elements (Johnson et al. 2012:563; Öhlén and Segesten 1998). This dynamism further reveals that professional identity emerges from a relational process involving identification of individual and collective difference to confirm and reinforce notions of group similarity and belongingness (Hall [1996] 2000 ; Jenkins 2014). Similarities between individuals and groups are based on common features, including 'origin...characteristics...or ideal[s]' social groupings or geographical locations (Cerulo 1997; Hall [1996] 2000 :16). As Stuart Hall ([1996] 2000: 17) claims, 'identities are constructed through [recognition of], not outside difference'. Despite agreement of this proposition by psychology and sociology, there is theoretical debate of origins of differences both across, and within the disciplines.



## **Personal approaches to professional identity**

Personal approaches to professional identity are underpinned by understandings which propose professional identity is informed by differences in 'natural or essential characteristics' (Cerulo 1997:386). This body of work draws heavily on the psychosocial theories of Erik Erikson to conceptualise professional identity developing over time through personal maturity and socialisation processes within education and training. For Erikson ([1959] 1980:109), identity denotes 'both a persistent sameness within oneself (selfsameness) and a persistent sharing of some kind of essential character with others'. The persistent internal sameness represents the core of one's personal values and beliefs, and these endure as a somewhat stable aspect of identity.

Identity is developed in phases whereby both internal, individual aspects and external, socio-cultural influences are significant, and movement from one phase to the next represents a process of maturity that focuses on self-confidence and trust. Drawing on the work of Erikson ([1959] 1980), professional identity is an 'integral', yet separate aspect of one's personal identity, and the latter is required for development of the former; it is the '*sense of self*' that arises from our experiences of work (Arthur 1990; Arthur

and Randle 2007; Johnson et al. 2012:563 *emphasis in original*; Öhlén and Segesten 1998:721).

Professional identity is an aspect of personal identity that has particular application to nursing, and includes an individual's perceived self-esteem in their ability to undertake the duties of the nursing profession. This comprehension makes conceptual connections with such psychological constructs as: nurses' self-image, nurses' identity, professional self-image (Öhlén and Segesten 1998), professional self-concept of nurses (Arthur and Randle 2007) and the multidimensional construct of nurses' self-concept (Cowin et al. 2008). Broadly, these conceptual associations encompass the attitudes nurses have regarding their evaluation of their own characteristics within the context of professional practice, including their individual limitations (Arthur and Randle 2007; Öhlén and Segesten 1998).

The development of professional identity arises from adopting 'the generalised perspective of other nurses', during professional socialisation (Arthur and Randle 2007:61; Öhlén and Segesten 1998). Socialisation is the on-going process that underpins personal and professional development whereby students internalise the 'values, norms and symbols of the

profession' during nursing education and training (du Toit 1995).

Evidence of low retention rates and worker dissatisfaction amid falling nursing numbers have made measurement of socialisation into professional identity a central research concern (ABS 2011; AIHW 2012b; Aiken et al. 2001; Hayes et al. 2012; WHO 2007). Several instruments, developed from comprehensive literature reviews and interviews, have been applied to Australian and international contexts for measurement purposes. These include:

- The Macleod Clark Professional Identity Scale (MCPIS-9) (Adams et al. 2006);
- Arthur's (1990) Professional Self-concept Nurses Instrument (PSCNI);
- The Nurses Self-Concept Questionnaire (Cowin 2001);
- The Nurses' Professional Identity Scale (Sharbaugh 2009); and
- The Professional Socialisation Scale (du Toit 1995).

The application of these self-reporting Likert Scale instruments show positive relationships between professional identity, retention rates of nurses and students, and worker satisfaction (Cowin et al. 2008; Sharbaugh 2009; Worthington et al. 2013). Yet, inconsistency of findings and questions surrounding reliability and validity of instruments raise

uncertainty of results (Cowin et al. 2013). This, however, does not discount quantitative findings altogether. Adam et al.'s (2006) application of the MCPSI-9 to understand factors influencing professional identity in first year Health and Social Care students yielded findings that were consistent with Worthington et al.'s (2013). These indicated that female students who had paid or unpaid vocational experience in the health sector recorded higher levels of professional identity when compared to those who possessed no vocational experience, or those who were male (Adams et al. 2006). Further Kelly and Courts' (2007) administration of the PSCNI demonstrates professional identity increases with both age and practice experience.

Explorations of personal values contributing to nurses' professional identities reveal that altruism and care are at the core of meaningful practice. This was typified by Fagermoen's (1995; 1997) longitudinal mixed methods study that found the values of altruism and human dignity were central to providing meaning to nursing practice. These findings are comparable to work indicating the personal characteristics of altruism, willingness to care, as well as the vocational nature of nursing practice, are central to students' career choices and nurses' professional identities (du Toit 1995; Fagermoen 1995; 1997; Rognstad, Nortvedt and

Aasland 2004). Qualitative research on Registered Nurses in Australia, and nursing students in Ireland also found the themes of vocational calling and caring under their career choices (Eley et al. 2012; Mooney, Glacken and O'Brien 2008). In addition, the subjective focus of this work revealed that the meaning of altruism was often confused, in that students and newly graduated nurses had expectations of reciprocity in their relationships with patients (Rognstad, Nortvedt and Aasland 2004). This is notable as it sits in opposition to popularly accepted image of the self-sacrificing nurse, and its association with socially constructed characteristics of gender (Bashford 1997; Godden and Helmstadter 2004).

Research shows professional identity is influenced by images of nursing that inform public perceptions of nursing's role and practice (Hoeve, Jansen and Roodbol 2013). Public opinion of nursing shape nurses' perceptions about themselves and the profession, and these underpin professional identity construction (Fletcher 2007; Grainger and Bolan 2006). Much of the public perception of nursing is shaped by the image of nursing portrayed in mass and digital media, and this contributes to both positive and negative professional identity construction (Dombeck 2003; Fletcher 2007; Hallam 2002; Hoeve, Jansen and Roodbol 2013). For example, Hallam's (1998; 2002) analysis of cinema, television, fiction and

recruitment material depicting nurses in the UK showed the feminine nature of nursing was predominant during the 20<sup>th</sup> Century, however, the image of nursing has been reshaped since World War II, and this was in line with a shift in managerial values and service discourse associated with the establishment of the National Health Service. Yet, Kelly, Fealy and Watson's (2012) critical discourse analysis identified the majority of stereotypical images of nurses on Youtube clips were negative. Their findings indicate little change in representations of nursing as they correspond to the images of nurses as 'battle-axes,...doctor's handmaidens', over-sexualised and incapable that were identified in literature reviews more than two decades ago (Bridges 1990; Hallam 1998; 2002; Kelly, Fealy and Watson 2012). Similarly, Kalisch, Begeny and Neumann's (2007) content analysis of Internet sites representing nursing, found that while nurses were portrayed as possessing expert knowledge and skills in the majority of cases, sexualisation of nurses increased between 2001-04.

While offering insights into some aspects of professional identity, personal perspectives are somewhat limited in their ability to provide an adequate understanding of the actual processes involved. This is because they are underpinned by a pursuit of objectivity that negates CCNs' subjectivities,

and thus, meaning-making of social actions and phenomenon are not considered, and therefore, personal perspectives can only offer single dimensional understandings (Neuman 2011; Turner, Beeghley and Powers 2007). Rather than proposing professional identity is simply an intrinsic part of personality, the sociology of professions can offer knowledge on how professional identity is constructed by social positioning and ideologies.

### **Ideological Constructions: Professions and professionalism**

Ideological constructions of professional identity are underpinned by critical conception of professions, professionalisation and professionalism. These concepts are evident in four sociological traditions; classic, interactionist, power and post-structural.

#### **Classic sociological approaches**

Classic approaches to professions arise from the functionalist thinking that dominated the sociology of professions until the 1960s. The concerns of these early approaches was to identify what differentiated professions and all other occupational groups (Macdonald 1995). While professions were not central to the writing of classic sociologists, they are alluded to in the writings of Max Weber ([1958] 2009; Weber, Gerth and Mills 1946) and Emile Durkheim (1957).

From the work of Weber ([1958] 2009; Weber, Gerth and Mills 1946), professions embrace the 'vocational' nature that characterised the practice of science in early industrial societies. For Durkheim (1957), professions were '*corps- intermediaires*', a social group whose function and role was to mediate between individuals and society's social and moral order. These ideas were furthered in the functionalist theories of Talcott Parsons (1939; 1968:536), where professions act as 'stabilising factors' against the economic self- interest that threatened the fragile social and moral order of industrial society (Carr-Saunders and Wilson 1933; Lynn 1963:653; Marshall [1939] 1963).

Professions were a normative economically disinterested social group that exhibited particular objectively defined structural positions, functions, roles and characteristics distinct from occupations (Macdonald 1995). They were characterised by an 'altruistic' nature and role in the provision of essential services, and relationships of confidentiality and trust with their clients (Marshall [1939] 1963; Parsons 1939; 1968:536). According to Parsons (1939; 1968:536), professions were guided by bureaucratic principles of functional specificity, affective neutrality and universal orientation. They were further distinguished from other occupational



groups by criteria of technically based education and training that emphasised the application of 'cognitive rationality' to a specific domain, a cultural tradition and an institutionalised code of ethics. Professional training and a cultural tradition were seen as integral to the internalisation of the characteristics of professional identity (Parsons 1939; 1968: 536).

In response to criticisms of functionalist approaches, particularly the work of Parsons, (1939; 1968) as being highly abstract, trait approaches aimed to distinguish professions from other occupational groups on the basis of identifiable professional characteristics, or 'traits'. Through objective empirical examination of traditional professions such as law, medicine and engineering, trait theorists identified the following professional attributes (Goode 1957; Millerson 1964):

- Altruism;
- A community sanction;
- Autonomy;
- Authority;
- An esoteric knowledge base;
- A regulative apparatus; and
- A code of ethics.

These traits have been applied to analysis and categorisation of fully developed professions such as medicine to distinguish these from 'para- or semi' professional groups such as teachers and nurses, and to qualify emerging professions such as social work and paramedicine (Etzioni 1969; Greenwood 1957; James 2013). Trait definitions suggest any occupational group capable of acquiring professional traits can attain professional recognition or professionalism through 'professionalisation' (Caplow 1966; Millerson 1964; Wilensky 1964). Caplow (1978: 139-40) defines professionalisation as 'process... (in which) an occupation passes through predictable stages of organisational change, the end state of which is professionalism'. Table 1 (on the following page) sets out professional traits and phases of professionalisation that inform nursing's professionalism and professional identity.

Despite helping to clarify what it means to be a profession, there are a number of issues with drawing on trait approaches to explain professional identity. The most obvious critique is the lack of consensus on the number or nature of professional traits (Macdonald 1995). Aside from this, the determinism of structuralist approaches denies the importance of subjectivity, despite it being an essential feature of human experience (Macdonald 1995; Neuman 2011). Further, criticism is cast at

**Table 1: Traits of professions and phases of Australian nursing's professionalisation**  
**(Goode 1957; Greenwood 1957; Keleher 2014; Wilensky 1964)**

Traits of Professions	Phases of professionalisation and <i>Nursing's professionalisation</i>
A community sanction	Specific work becomes a full time occupation  <i>Charity based nursing</i>
An occupational culture	Establishment of training institutions  <i>Hospitals established mid- 19<sup>th</sup> Century</i>  <i>Arrival of Nightingale trained nurses in Australia</i>  <i>(Royal) College of Nursing Australia established 1949</i>
A regulatory framework	Establishment of associations and regulatory apparatus  <i>Formation of Victorian Trained Nurses Association 1902- followed by five other States</i>  <i>Political support for State-Based Nursing Registration Boards 1920s</i>
Possession and development of a systematic knowledge base  Autonomy  Authority	Establishment of training within tertiary education  <i>Transfer of Nursing Education and Training tertiary education institutions 1985</i>  <i>Creation of Advanced Nurse Roles 1990</i>
Code of ethics	Introduction code of ethics  <i>Code of Ethics for Nurses in Australia July 1993</i>

methodologies of trait approaches for doing little more than reflecting specific professions' ideological view of themselves (Johnson 1972). This implies a homogeneous group, with all members sharing the same interests, values and beliefs, when empirical evidence argues otherwise (Belle and Willis 2013; Bucher and Strauss 1961).

A focus on traits results in static explanations of a universal social group unaffected by historic or socio-cultural contexts, despite professions being a predominately Anglo-American phenomenon (Macdonald 1995). The static nature also indicates occupational groups professionalise through a 'uni-linear' progression towards an unidentifiable end point without considering social, political, economic and histo-cultural contingencies of specific historic contexts (Abbott 1988; Evetts 2003; Johnson 1972:37). The outcome is a 'monocratic' ideal type occurring outside the context of social, economic and political forces. As this neglects the processes that brought particular professions, such as nursing, into being, it cannot account for how social forces shape professions' everyday practice, or how the group or their practice, may possibly adapt to social change. Moreover, trait understandings cannot offer insight as to why some professional groups (such as medicine) receive disproportionate economic

and social rewards over others (such as nursing) (Hughes 1958; Turner 1987).

Despite the heavy criticism levelled at structuralist theorises of professions, they do provide guidance on the characteristics that professional identity may, or may not incorporate. For example, Chaboyer, Najman and Dunn (2001b) found a positive correlation between autonomous practice, worker satisfaction, and job valuation, which suggests that autonomy is significant to nurses' professional identity. Moreover, the ideal type offered by the concept of professions informs both lay understandings and professions' view of themselves. Accordingly, it serves as analytic instrument to explore discrepancies between the ideal and reality of professional identity in everyday working life within interactionist approaches.

### **Interactionism**

Interactionist approaches propose social reality and social actor's positions within it are constituted by subjective meaning-making processes of social actions and phenomenon. In this way, professions and professional identity are constructed around meaning-making of the undertaking of work activities. Emerging from the micro-level social ecological

framework of the Chicago School in the 1950s, interactionist understandings of professions are most notable in the seminal work of Everett Hughes (1958; 1971) and Howard Becker and colleagues (1961). Rather than seeking to define or distinguish professions from occupations as with functionalist approaches, this action based perspective sought to explore what it was that professions actually “did” in a practical sense, that made them professional (Macdonald 1995).

Hughes’ (1958; 1971:292) ethnographic focus underpins his argument of the difference between occupations and profession being of ‘degree rather than kind’. All occupations possess a ‘licence’, or community sanction to undertake specific activities for remuneration (Hughes 1971:287). What distinguishes professional groups is a strong collective identity and solidarity that enables them ‘claim a mandate’ (Hughes 1971:287) over specific areas of knowledge and work activities, or what Abbott (1988:64) terms ‘jurisdictions’. A professional mandate enables the group to establish acceptable behaviour and conditions of work and aim to extend their control over social, cultural and political areas of social life, thus shape the state’s, and society’s thinking in regards to their identified expert area (Hughes 1971: 287; Abbott 1988). Therefore, from an interactionist framework, professions are a value-laden status group

constructed around a self-serving ideology of maximisation of social and material rewards (Adams 2010; Macdonald 1995).

Hughes and colleagues took an ethnographic approach to explore the professions of medicine in *Boys in White* (Becker et al. 1961) and *Medical Dominance* (Freidson 1970a), and nursing in *Twenty Thousand Nurses Tell their Story* (1958). These works found major discrepancies between the ideal construction of professions, and the everyday realities of their practice, or to put it another way, a tension between licence and mandate. The work of professionals involved the performance of dirty work, the exchange of guilty knowledge, unintended mistakes, domination and cynicism, rather than altruism. Moreover, this approach was central to revealing how the professionalisation of American nursing involved 'task resorting' (Hughes 1971), by which prestigiously viewed tasks of other health professions were incorporated into nursing as a result of higher educational content of training. Simultaneously, less prestigious and mundane of nursing tasks were discarded to less educated auxiliary health workers whose positions have often been created for such purposes, in return for increased social mobility and prestige (Hughes 1971).

Interactionist research projects that explored nurses' professional identity have uncovered a variety of tensions. The most common of these is a disconnection between the ideal constructed by the profession of nursing and expectations of governments and employing organisations, as well as those of students and nurses (Currie, Finn and Martin 2010). These tensions arise from the 'theory-practice gap', which is well recognised within reviews of nursing literature and qualitative studies (Bendall 1976; Monaghan 2015). Maben, Latter and Macleod Clark (2006) found that while new graduates developed a strong sense of professional values such as holistic and individualised care during education and training, they become dominated by values of the health bureaucracies in which practice takes place. This has been shown to increase work stress, which negatively influence both worker satisfaction and professional identity construction (Arreciado Marañón and Isla Pera 2015; Bartram, Joiner and Stanton 2004).

In reviewing ten years of ethnographic data, Allen (2004) asserts that nursing practice is far from the professional ideal of holistic and individualised care. Rather nursing practice represents a mediatory position between the patient and the needs of the health care organisations. This is suggestive of a weak professional claim which is found to contribute to lowered worker satisfaction levels, and in response,



Allen (2004; 2007) argues that nursing's professional identity could be strengthened by reconstructing nursing's mandate to more accurately reflect the realities of practice.

Grounded theory research conducted in Canada, the United States and Australia has found nurses' professional identities are not only developed during socialisation, but are instead actively and continually constructed, negotiated and reconstructed as nurses move through various phases of practice (Deppoliti 2008; MacIntosh 2003). This process was described in Gregg and Magilvy's (2001) exploration of Japanese Registered Nurses' development of professional identity as 'bonding into nursing'.

Ethnographic studies focusing on professional identity processes have demonstrated the importance of spatial, temporal, gendered and political influences, and how individual nurses negotiate and adapt in response to these (Allen 2000; Brooks and MacDonald 2000; Halford and Leonard 2003).

While interactionist perspectives of professions can inform our understanding of professional identity at the individual level, they are critiqued for failing to offer an adequate understanding of the inherent political nature of these processes. In reply, I draw on Strauss' (Strauss

1978:13) assertion that 'negotiation indicates conflict', and previous interactionist work focusing on doctor-nurse interactions to argue the framework can account for micro-political processes (Allen 1997; Coombs 2003; Manias and Street 2001b). However, in order to gain fuller appreciation for the political nature of professional identity construction within the micro-level work context, it is necessary to consider the use power approaches to professions.

### **Power approaches**

Power approaches, as the name suggests develop and emphasise the political nature of professional identity. The central themes are extensions of interactionism; the employment of occupational role to achieve upward social mobility and increase social rewards through claims to expert knowledge and its practical application (Macdonald 1995). The approaches are a synthesis of neo-Marxist, neo-Weberian and feminist frameworks that assert 'a profession is not an occupation-rather a means of controlling an occupation' and professionalism, or occupational control, is the end result of professionalisation' (Johnson 1972:45).

Eliot Freidson's (1970a; 1970b) ethnography of the medical profession in Australia is foundational to understandings the political nature of

professions, professionalisation and professionalism. This work combined the micro-level details of Hughes' (1958; 1971) with Weberian thinking to describe the processes underpinning occupations' attempts to attain and preserve their power, autonomy and status. To Freidson (1970: 71), professions are a social group characterised by 'organised autonomy', which enables them to 'transform, if not create, the substance of their own work' (Martimianakis, Maniate and Hodges 2009:832). While this work has given considerable insight into processes of occupational control which are developed within neo-Marxist and Weberian frameworks, it is limited as it extends trait approaches to include any group that has achieved occupational autonomy (Macdonald 1995).

The use of Marxist theory to explain professionalism as a means of securing state sanctioned monopolistic control over a specific occupational area is evident in British sociologist Terrence Johnson's *Professions and Power* (1972). This analysis advanced French sociologists Jamous and Peloille's (1970) ideas of professions' characterisation of their work as indeterminant (uncertain), rather than technical to protect their occupational area from encroachment by other occupational groups. Johnson (1972: 43) draws on data from the Institute of Commonwealth Studies to explain how professions as producers maintain social distance

from their clients as consumers to maximise practitioners' 'potentialities for autonomy'. His work offers a three tiered typology of professionalism that accounts for the differential rewards between professions based on their form of professionalism. Each form of professionalism; collegiate, patronage and mediatory is characterised by particular economic relations. Of these, the professionalism of nursing exemplifies mediatory control, that is, the state determines both the services the group delivers and those consumers receive. Medicine, in contrast, represents collegiate control, where the needs of consumers and the means in which they will be met are determined by the professional group (Johnson 1972:45). While this model has not been empirically applied, its principles are evident in analysis of policy documents suggesting professionalism equates with direct government regulation such as the British NHS (Timmons 2011). Despite its benefits, the framework suffers from the same objective determinism of Marxist explanations generally (Macdonald 1995).

Magali Sarfatti Larson's (1977) historic analysis of professionalisation overcomes determinism by synthesising interactionist, Marxist and neo-Weberian ideas to focus on the part of knowledge in establishing a market for services, and the accompanying social mobility and relations of inequality. Her work develops the work of Freidson (1970a; 1970b) to

define professionalisation as a process of occupational control over professional knowledge as a marketable resource in exchange for material and social rewards. Utilising the term 'professional project', she describes professionalisation as a deliberate, collective strategic process by which professions gain a state sanctioned 'occupational monopoly' within the capitalist free market. Larson's (1977: xvii; 1980) central interest is:

*why it is that some occupational groups flourish from converting an 'order of scarce resources...special knowledge and skills...into another...social and economic reward' over others.*

She identifies three aspects of successful professionalisation: production and maintenance of esoteric knowledge; cultivation and maintenance of an expansive clientele base; and the maintenance of specific privileges at the focal point of work (Larson 1977; 1980; Turner 1987: 137-38). These three aspects combine to ensure market control through processes of exclusion and social closure as described by Weber (1978), and are typified in nursing's professionalisation (described under the heading 'The Professionalisation of Australian Nursing' on page 26).

A number of studies have applied Larson's (1977; 1980) ideas of social closure to explain modern inequality of social material rewards between occupations at the macro generally. Anne Witz's (1992) historic study

applied a similar framework to overcome the gender bias of previous analyses of professions. Examining the professions of medicine, nursing and midwifery, she argues a patriarchal capitalist society enables men to determine the value placed on particular forms of knowledge. She describes how established male dominated professions such as medicine place high economic value on rationally based systematic knowledge they espouse, thus ensuring high prestige and accompanying material rewards. In constructing nursing to be a 'a woman's province' by nature, male dominated professions reproduce gendered inequality (Bucher and Strauss 1961: 61; Cockerham 2003; England 2005). Witz (1992) ascertains medicine has historically employed four strategies of occupational closure: inclusion; demarcation; inclusion; and dual closure, to extend the privilege of white middle class men.

The devaluing of assumed feminine characteristics of nursing is indicated by gendered differences within the profession. Statistics indicate the number of men opting for a career in nursing has risen to an estimated average of 10% of the nursing workforce in Australia (AIHW 2012b), the United States and Nordic nations (Abrahamsen 2004), however, literature suggests males enter nursing for different motivations than their female counterparts. Males are more likely to nurse for instrumental reasons,

associated with the traditional 'breadwinner role', such as rewarding remuneration, the social acceptability of the profession and on-going job stability (Muldoon and Reilly 2003; Zysberg and Berry 2005).

Males additionally segregate to areas within nursing considered to be masculine, such as specialty areas that are highly acute and characterised by high levels of medical knowledge and technological intervention, including emergency and critical care, and senior administrative positions (Dassen, Nijhuis and Philipsen 1990; Evans 2004; 1997; Snyder and Green 2008). Whether disproportionate number of males in senior positions is due to assumptions of leadership qualities as masculine is contested in the literature (Simpson 2004; Snyder and Green 2008), however there is agreement that male nurses position themselves in areas where rational logical knowledge is valued, and thus, construct themselves as masculine through separation from the feminine caring aspects of nursing practice (Brooks and MacDonald 2000; Simpson 2004).

### **Post-structuralist approaches**

The processes of exclusion and social closure that professionalisation and professionalism represent are also explained through application of the writings of Bourdieu (Bourdieu and Wacquant 1992). Professions are

critiqued as an objective social group, and rather are representative of a 'field'; a set of social relations in which conflict takes place over the legitimisation of particular forms of capital. Capital is not only economic, but extends to include social, cultural and symbolic capital, which can be converted into material assets. Of these, cultural capital encompasses three states; 'embodied, objectified and institutionalised' (Bourdieu 2011 [1986]:84). One's embodied cultural capital is associated with one's habitus; 'an ensemble of dispositions' (Abercrombie, Hill and Turner 2006) that guides actions and attitudes and institutionalised cultural capital refers to formal recognition of nursing knowledge and accreditation.

The ideas of Bourdieu have been applied to narrative studies of altruism and vocation in nursing that argue these values are more fully understood as a form of cultural capital, rather than simply a spiritual perspective (Carter 2014). Kontos and Naglie (2009) combined Bourdieu's concept of habitus with the phenomenology of Merleau-Ponty to argue that an embodied self-hood is fundamental to the development of tacit knowledge. Reviews of literature of social and cultural capital have also been applied to nursing in an attempt to discover social and cultural drivers of nursing's professionalism in the UK (Royal 2012).



Larson's (1990) later work draws on the post structuralist ideas of Michel Foucault (1973; 1980) to explain professionalisation projects as influenced by social, historic, economic and political change. She draws on the power of discourse to argue professionalisation is a process of construction and legitimisation of particular knowledge bases and a market for their practical political application. Foucault (1972:117) defines discourse as:

*a group of statements in so far as they belong to the same discursive formation ... [discourse is] made up of a limited number of statements for which a group of conditions of existence can be defined.*

Discourse underpins Fournier's (2000) argument that professions do not arise from the division of labour, but rather, the discursive 'labour of division'. As Bowker and Star (1999: 5) point out, discourse 'valorises some point of view and silences another'; professions' discursive constructions legitimise their specific knowledges, and thus their areas of control are demarcated through inclusion, while excluding others.

The discipline of nursing has adopted Foucauldian perspectives to extend understandings of nurses' identities and nursing practice. In reviewing nursing literature, Gastaldo and Holmes (1999) found Foucault's (1980) ideas evident in twenty seven publications which drew on concepts including discourse, the clinical gaze, power/knowledge, surveillance,

discipline, resistance, docile bodies, clinical gaze, and panopticon.

Researchers argue these concepts, and the application of a genealogical framework provides new methods to critically pose questions on the professional status of nursing and nurses, and construction of professional identity (Gastaldo and Holmes 1999; Miró-Bonet et al. 2013).

Post-structural studies on nurses in Australia and Scotland found specific discourses were central to different constructions of nursing practice and professional identity. May's (1992) Scottish study found a discourse of the social was central to medical and surgical nurses' practice, despite this being challenged at the practical level, whereas Copnell's (2008:590) Australian study found CCNs' drew on a discourse of knowledgeable practice to construct themselves as 'good nurses'. Alternatively, nurses working in inter-professional partnership in the UK differentially emphasise particular discursive aspects to legitimise their jurisdictional claims in opposition to other team members (Sanders and Harrison 2008).

Despite the benefits post-structural approaches provide in uncovering the power of discourse in shaping CCNs' professional identity constructions, the perspective is not without critique. A central issue within this

tradition, particularly the work of Foucault (1980), is it neglects the power differentials inherent to gendered relations. As nursing is a female dominated profession, application of post-structural frameworks cannot adequately explain the influence of gender, and how it may, or may not, promote or constrain professional identity. Moreover, the abstractness of post-structuralism implies CCNs lack consciousness of the influence of gender and power, when empirical work from other perspectives readily challenges this proposition (Dombeck 2003; Willis and Parish 1997). To gain more comprehensive understanding professional identity, there is more advantage in applying interactionist perspectives which conceptualise it as associated with enacting the role of a specific social identity.

### **Professional identity: professional and nursing role**

This perspective of professional identity is also associated with the symbolic interactionist tradition of the Chicago School (discussed under the subheading 'Interactionism' on page 54). Within this approach, work is a social interaction whereby an individual performs a 'social role, a part one plays in a drama' that informs social identity construction (Hughes 1971:314). This idea is similar to the dramaturgical approach of Erving Goffman (1959) in *The Presentation of the Self in Everyday Life*. To Goffman,

identity is performed and negotiated by interpreting and meaning-making of social signifiers as 'props' during interactions, similar to a context bound stage-play.

The principles of interactionism emphasise identity is not uni-lateral; it is a simultaneous process of self-identification, identification of others, and others' identification of us (Goffman 1959; Jenkins 2000; 2014). While social actors possess agency to manage presentations of their identity in particular ways, they are unable to shape the impressions of others (1959; Jenkins 2000; Jenkins 2014). For example, a nurse's uniform signifies a specific social identity, namely that of a nurse. While an individual nurse's subjectivity experiences informs their identity as a nurse, other individuals recognise a nurse's uniform and associate it with their expectations of being a nurse. In this way, identity is confirmed or challenged, and ultimately negotiated in a reciprocal process. Further, the social context of the ICU stands as a backdrop to the particularities of CCNs' performance of their professional identities which are judged by patients, patient's families, other nurses, other health workers and doctors.

The expanding and extending of nursing roles, as well as the development of new nursing roles since professionalisation, has meant research of the

topic continues to increase, however there is little consensus of descriptions in neither international nor Australian contexts (Lowe et al. 2012; Williams, McGee and Bates 2001). Moreover, the movement of work activities from nursing's jurisdiction to auxiliary workers, and the adopting of activities from medicine, are found to make the nurses' role ambiguous (Merrick et al. 2012; Pearcey 2008; Piil et al. 2012). Some of this uncertainty also arises from the broad range of nursing role titles, and new specialist Advanced Nurse practice roles being developed and established at State, rather than a National level in Australia, however, not all (Driscoll et al. 2005; Gardner et al. 2017).

Empirical evidence finds CCNs' roles are especially characterised by ambivalence, as medical staff and technology, as well as organisational structures, contour their boundaries, particularly in the Australian context (Coombs, Chaboyer and Sole 2007; Lowe et al. 2012; Merrick et al. 2012).

Issues of role ambiguity are also found in international and Australian qualitative studies on specialty nurses working outside the acute nursing sector, including Mental Health Nurses, Nurse Educators and Midwives (Bower, Jerrim and Gask 2004; Crawford, Brown and Majomi 2008; Hercelinskyj et al. 2014; Larsson, Aldegarmann and Aarts 2009; Sayers et al. 2015). Role ambiguity is empirically found to negatively impact on

work stress, work satisfaction and retention levels of general and specialty nurse roles, including CCNs (Chen et al. 2007; Iliopoulou and While 2010; Sharbaugh 2009).

### **Medical dominance**

Theorists espousing medical dominance are dubious of nursing's claim to professionalism. Freidson (1970a; 1970b) is among others (Etzioni 1969; Turner 1987), who critique nursing's claim to a unique knowledge base, arguing that nursing merely borrowed its knowledge from medicine.

Freidson goes on to argue that if nursing's knowledge base is underpinned by medicine, nursing's claim to autonomy is questionable.

This premise underpins arguments against nursing's professionalism, as it suggests the group represent only semi, or 'para'-professionals, subordinated to the direction of medicine (Etzioni 1969; Freidson 1970a; 1970b; Turner 1987). These theorists assert that nursing can only claim autonomy when their practice involves the direct questioning of medical decisions and treatments. Until then, nurses only carry out the directions of the medical profession. This indicates that the incorporation of increasingly technical tasks associated with development, extension and expansion of the nursing role is not due to nursing's professionalism.

Rather it is the result of social, technological, economic and organisational influences by which health professionals passing off more mundane and

dirty tasks down to the jurisdiction in the manner described by Hughes, Hughes and Deutscher (1958).

Sociologists perceive the division of health labour results from the dominance of medicine (Freidson 1970b; Willis 1989; 1994). Freidson (1970a; 1970b:188) describes medicine as the profession *par excellence* for its ability to control the resources, knowledge bases and work activities of other health professions, including nursing. While Willis (1989;1994) suggests that the medical profession maintains its dominance, and associated privileged economic social position through the of strategies of subordination, limitation, exclusion and incorporation to restrain competing health practitioners, empirical evidence indicates that nursing has emulated other occupational group's resistance to medicine's dominance and distinguished itself as a health profession. This suggests nursing is an emerging profession, only one of many vying for professional recognition within health care provision.

Nursing's challenge to medical dominance is well theorised. Similar to other health professions, nurses are involved in an on-going process of negotiation of the jurisdictional boundaries with medicine in the course of

their everyday work in what Abbott (1988) terms workplace assimilation. The boundaries between health professions are not rigidly set in stone but are constantly constructed and reconstructed under the influence of work environment, resource allocation, occupational ideologies and technological advances within a dynamic system (Abbott 1988; Nancarrow and Borthwick 2005). Furthermore, social, cultural, economic and technological change, coupled with nursing's extension and expansion has resulted in a 'blurring of boundaries' between health professions (Harmer 2010; Snelgrove and Hughes 2000; Tye and Ross 2000). This has weakened traditional lines of professional demarcation and promoted their negotiation by health professionals.

Working in a negotiated order framework, Stein (1967) initially argues that nurses engage in what he terms 'a doctor-nurse game', whereby they manage their interactions with doctors so as to appear subordinate while acting autonomously, and thus promote the latter's superior position within the health care hierarchy. Although this may have been the situation in the 1960s and 1970s, changes to health care provision, including the increasing level of knowledge associated with nursing's professionalism sees reconsideration of this process (Stein, Watts and Howell 1990). Rather than interactions being typified by what Porter



(1991:728) categorises as the 'unproblematic subordination' and 'informal covert decision making' in Stein's (1967) initial description, nurses now engage in 'informal overt decision making' , 'formal overt decision-making' and non-negotiated decision-making (Allen 1997; Svensson 1996) processes across the traditional boundaries of nursing and medicine.

### **Boundaries and boundary work**

While the concept of boundary work originated in the cultural anthropological work of Frederick Barth (1969), it is central to explaining professions' formation, reproduction and professionalism. Barth (1969) used the term to apply to the performance of difference between ethnic tribes, and it is adapted within the sociology of professions to refer to the way specific professions distinguish themselves from one another, other occupational groups and from their (professions) clients (Abbott 1988; Gieryn 1983). Gieryn (1983) utilised the concept of boundary work to allude to the way that scientists distinguished themselves from amateurs through the construction of boundaries of 'true' science utilising specific discourses to construct 'rhetorical boundaries between' that which is science and alternative 'less authoritative...non-science' (Gieryn 1983: 781; 1999).

The concept of boundary work is of value in understanding nursing's professional project as 'strategic practical action' (Gieryn 1999: 23). At the macro level, nursing's boundary work involved the formation and isolation of an 'independent and self-contained field of knowledge' upon which notions of its professional authority and exclusivity are founded (Fournier 2000: 69). This field functions to erect boundaries between nurses and other professional groups. Nursing's legitimised claims to scientific founded knowledge acts to establish symbolic and social boundaries between itself and other occupational groups that are founded on lay knowledge (Fournier 2000; Gieryn 1983).

Lamont and Molnar (2002) differentiate between the concepts of symbolic and social boundaries. Symbolic boundaries are abstract conceptual differences that social actors attach in the process of categorisation of 'objects, people, practices, time and space' and are employed in the process of contestation and definition of specific social realities (Lamont and Molnar 2002: 168). Symbolic boundaries are an inter-subjective means by which individual and collective social actors achieve status and a monopoly over scarce resources and are established by the use of discourse (Fournier 2000; Larson 1990). The establishment of agreed symbolic boundaries serves to enforce social boundaries (Lamont and

Molnar 2002). Social boundaries are 'objectified forms of social difference' that are represented by levels of inequality.

In the case of professions, an independent field of knowledge serves as a symbolic boundary that establishes and reinforces social privileged through excluding its access within society as described by power theorists (Fournier 2000; Larson 1977; 1990). In the case of nursing, the symbolic boundary of medical knowledge, and the patriarchal assumptions that accompany it, serves to enforce a social boundary that promotes inequality between the two professions. That inequality is manifest in the differential amounts of social and economic prestige awarded to medicine over nursing. While boundaries act as an exclusionary mechanism, it must be understood they also play a role in the generation of experiences of familiarity and group acceptance.

A profession's collective identity is strengthened through boundary work as the process aims to promote the inferiority of others (Dingwall 2008; Fournier 2000; Gieryn 1983; 1999). This involves the adoption of an 'us' and 'them' group mentality that emphasises a distinction between internal and external group differences that is played out at the micro level (May

and Fleming 1997). Empirical work of nursing's professional identity finds distinctions are based on specific symbols that include forms of language and particular narratives, cultural objects, clothes and rituals (Dingwall 2008; Sanders and Harrison 2008; Timmons and East 2011). Sociologists (Dingwall 2008; Turner 1986) suggest that particular forms of narratives are employed to emphasise a profession's boundaries and promote group solidarity. 'Vocabularies of complaint', or 'atrocities stories' (Allen 2001:77; Dingwall 2008; Turner 1986: 354), are negative accounts of the practices of other professions in situations when professional identity has been threatened. Atrocities stories are characteristically shared openly between members in order to inform younger members of the profession of demarcated professional boundaries and confirm the professional identity of the group (Dingwall 2008; Allen 2001; Turner 1986).

The consideration of professional boundaries also applies within the nursing profession as by no means is the group homogenous in work activities or interests. Rather, nursing can be conceptualised as a 'loose amalgamation of segments' attached to a collective title (Bucher and Strauss 1961: 326). Nursing specialties are differentiated in work tasks, approaches, methods, aims and ideologies and represent a fragmentation of interests with nursing. As such, contingencies within nursing and its

adjacent professions influence nursing specialties in different ways (Bucher and Strauss 1961; Smith 1958), and it is these differences that this study aims to capture.

## **Conclusion**

This chapter has reviewed the theoretical literature and empirical work related to CCNs' practice and professional identity. In presenting the three themes of professional identity; personal approaches, ideological constructions and the role of professional nurses, it revealed the personal, interpersonal and socio-historic dimensions of professional identity, and showed how the concept is understood both objectively and subjectively. The practice of CCNs is a principal research interest due to its distinct technological and collaborative nature, and while it has been a focus of qualitative and quantitative work, there is little evidence on CCNs' professional identity constructions. This represents a significant empirical gap, which if not addressed, could contribute to heightened ambiguity of professional identity, and the negative consequences that are associated with it.

While trait and power approaches offer benefit in understanding how professional identity is informed at the structural level, they offer little in

the way of providing an understanding of the micro processes involved in professional identity construction within everyday specialty nurse practice. To overcome this limitation, this thesis is informed by a micro-interactionist perspective that applies the concept of boundary work to the level of the individual CCNs. Such a position enables the process of CCNs' professional identity constructions to be posited as informed by the performance of work tasks associated with their specific professional jurisdictions. In addition, an interactionist framework enables the adoption of a social ecological perspective to consider how the professional identity construction of nurses within one specialty is influenced by adjacent health professions. This micro approach enables exploration of the subjective meanings that CCNs attach to symbols and rituals through a focus on their language and actions and how these are employed to construct and negotiate professional boundaries.

In the next chapter, 'Methodology and Method', I move to discuss the social constructionist framework of this study, and the adopted methodology of ethnography. The approach of the study and evaluation of rigour are detailed, and the reflexivity that is central to qualitative methodologies is considered.



## CHAPTER THREE

# Methodology and Method

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### **Introduction**

The aim of the study was to explore how CCNs make meaning of their professional identities. Of particular importance, was the description and interpretation of CCNs' meanings of actions, language, rituals and application of artefacts within their practice, and how these were drawn on to construct their professional identities. It was essential to adopt a methodology that could capture CCNs' meaning-making processes to achieve these aims. This research applied an inductive qualitative methodology in the form of ethnography; data were generated from ninety-two hours participant observation of CCNs in their natural working environment of the ICU, and eight semi-structured in-depth interviews. In this chapter, I outline the qualitative methodology and design of the study, as well as challenges faced in the field. The chapter begins by describing the adoption of an interpretivist methodology before it move to a detailed discussion of the employed methods of semi-structured in-depth interviews, participant observation, and thematic analysis. Given the priority placed on reflexivity within qualitative methodologies, the chapter incorporates reflection on my position as



researcher within the study. Finally, the ethical concerns and limitations of the study will be presented, however I begin by turning attention to the overall aims of qualitative research, and justification of my choice for this research.

## **Methodology**

### **Interpretivism and constructionism**

The focus on CCNs' constructions and negotiations of professional identity guided the selection of an interpretivist approach. Interpretivism arose from the work of German philosopher Wilhelm Dilthey (1989[1883]), and was advanced within the interpretive sociology of Max Weber (1981; Weber, Gerth and Mills 1946). The approach distinguishes between the purposes of the natural and social sciences; the purpose of natural science is 'scientific explanation' (*Erklären*), whereas the goal of cultural sciences is the 'understanding the meanings of social phenomenon (*Verstehen*)' (Erikson 2011; Schwandt 1998:223).

From an interpretivist perspective, individuals make sense of social reality through the attachment of socially context-bound meanings to social actions and phenomenon (Schwandt 1998). In the case of this study, the meanings of professional identity are shaped by each CCN's historical and

socio-cultural context, and *verstehen* refers to the researcher's ability of to place themselves within these contexts to interpret participants' meaning-making (Crotty 1998).

The interpretivist framework of this study was informed by a social constructionist stance. Social constructionism is a philosophical position that forms a branch of interpretivism. Therefore, it supports the study's focus on accessing, describing and interpreting CCNs' subjective meaning-making (Cresswell 2013). Social constructionism, or simply constructionism, was initially demonstrated in the work of Berger and Luckmann (1966), who argue knowledge is constructed through negotiation of meanings during individual interactions. From their perspective, society is seen as both objective and subjective. The processes of routinisation and habitualisation act to institutionalise meanings. The institutionalisation of individuals' subjective meanings results in assumptions of their objective basis, and these shared understandings are transmitted through language (Berger and Luckmann 1966; Berger 1963). From this perspective, knowledge is subjective, therefore it is shaped by specific biological, socio-historic and cultural forces from within the context of its creation (Lincoln, Lynham and Guba 2011).

Social constructionism extends along a continuum from mild to extreme.

As such, the adoption of constructionism within this thesis requires further specifying. Extreme constructionists deny any objectivity of social reality, meaning they argue the existence of:

*multiple realities in the form of ...mental constructions, socially and experientially based...dependent for their form and content on the persons that hold them (Guba 1990:27).*

This suggests social reality in its entirety is a social construction; that all reality and all knowledge are mental representations with no objective basis. As such, any researcher's views constitute a construction, and therefore, no claims can be awarded value as being legitimate over others. My own position is that of a mid-range social constructionist, that is, I assume there is an objective aspect to social reality and accept the existence of social phenomenon, but I conceive the naming and categorisation of these is subjectively based. For example, I acknowledge the objective existence of the space of the ICU and the CCN role under exploration, but recognise CCNs' meanings of these are subjective.

Understanding CCNs' professional identities from a constructionist perspective involved placing myself within the natural environment of CCNs' working lives, and thus, engaging in co-construction of their

subjective meanings. Constructionism proposes that meanings are not fixed, but rather they are constructed and negotiated between CCNs from within their particular social contexts. Therefore, my interactions with CCNs provided opportunities to co-construct the meanings of their subjective understandings of professional identity, and thus, I gained knowledge on the topic (Berger and Luckmann 1966).

The task of acquiring knowledge of CCNs' meaning-making was most suited to an inductive qualitative research methodology, drawing on the principles of ethnography. However, I should accentuate that the study was not ethnographic in the traditional sense, as the aim was not to describe and interpret CCN culture in its entirety (Gobo 2008). Rather, ethnographic techniques were adopted to focus on a single aspect of CCN culture; namely the processes of professional identity. These techniques included entering the natural setting of CCNs' workplace to study their everyday work activities to understanding their shared meanings of professional identity. The generation of textual data from the ethnographic methods of participant observation and semi-structured, in- depth interviews described the quality of CCNs' experiences (Bryman 2004; Marvasti 2004). Thus, ethnographic methods enabled description and interpretation of how CCNs construct meaning of professional identity in the 'concrete settings' (Dickinson and Peeters 2014:5) of their everyday

work environment that were 'idiographic' (Denzin and Lincoln 2008:12), or context specific (Mason 2002).

## **Ethnography**

Ethnography is a methodology that arose from cultural and social anthropology, where it was initially utilised by Europeans to examine foreign tribal cultures during the late 19<sup>th</sup> and early 20<sup>th</sup> Century (Gobo 2008). The word "ethnography" literally translates from the Greek words *ethnos*, (people or folk), and *graphy*, written description, and is defined as the 'art and science of describing' a culture sharing group (Agar 1980; Fetterman 1989:11). A culture sharing group refers to a social group bound by a common learned system of knowledge, beliefs, values and symbols that are demonstrated through 'observable externalities' such as language and actions within specific social settings (Neuman 2011:423). Within this study, CCNs are defined as a culture sharing social group based on their commonly shared nursing knowledges, accompanying language and work activities within the social context of the ICU.

Ethnography is a widely utilised methodology in sociology. Originally adopted and developed by the Chicago School in the early decades of the 20th Century, it is popularly applied to contemporary social science,

education and health research. Ethnographies of health professions are most notable in seminal symbolic interactionist works such as *Boys in White: Student culture in medical school* (Becker et al. 1961), and Everett C. Hughes' *Men and Their Work* (1958). Ethnography was essential to understand professionalisation of American nursing by Hughes and colleagues in *Twenty Thousand Nurses Tell Their Story: A Report on Studies of Nursing Functions sponsored by the American Nurses' Association* (1958). This latter work offered significant findings of nursing's professionalisation a process of task 'resorting', whereby nurses 'picked up' more technical and prestigious work tasks, while handing down tasks that were considered more mundane to lower ranked workers (Hughes 1971:314). While this early work was critiqued as unsystematic (Dingwall 2008), ethnography is still significant in extending knowledge of professions, particularly nursing, as culture sharing social groups. For example, it has been applied in research of health professions, particularly to explore boundary work between, and within professional groups (Allen 2000; 2001; 2004; Bucher and Strauss 1961; Dingwall 2008; Manias and Street 2001b).

The focus of this ethnography was describing and interpreting the shared meanings that inform CCNs' professional identities from two inter-related perspectives: *emic* and *etic*. *Emic* refers to an insider perspective, or what

Malinowski (2002:22) terms the 'the native's point of view', whereas an *etic* perspective refers to an outsider view, and this allows for theoretical interpretation of emic understandings. The emphasis of interpretivism is data generation and analysis through co-constructing meaning between participant and researcher. This, and the necessity of emic and etic understandings, required me to be reflective on how my nursing experience and position as a researcher influenced co-construction.

### **Reflexivity and 'the space between'**

Reflexivity was central to evaluation of the study as it enabled acknowledgement of my own subjectivity and thus, minimisation of its influence on all stages of the research. Reflexivity is 'a process of constant, self-conscious scrutiny of the self as researcher and of the research process' (England 1994 in Dowling 2010:31). In adopting the practice of reflexivity, I critically reflected on the reasoning behind processes, and tried to challenge my own assumptions and acknowledge the degree to which my values, beliefs and actions influenced the research.

Adopting reflexivity provided an 'explicit self-awareness of... (my) own role' as a researcher and thus, I was mindful of how my previous working life as Enrolled Nurse influenced all processes and decision-making within

the study (Finlay 2002:531). While no longer registered to practice, I still have insight into nursing culture and identity, and being reflexive challenged these assumptions, and enabled recognition of my values and beliefs, and their influence within the study.

In the role of researcher, I prioritised the ethical generation, description and interpretation of data to represent the experiences of informants' social realities and 'life worlds' (Mason 2002; Schutz and Luckmann 1973). Therefore, it was necessary to acknowledge describe and interpret how my social positioning shaped every stage of the research process. My position as a white, middle aged, lower-middle class female with private secondary, and tertiary education, as well as my previous Enrolled Nursing experience influenced the project both in terms of the decisions made and of participants' responses. This encompassed the shaping of the research question, the development of the research design, the generation and analysis of data and the process of writing up findings. For example, recruitment of participants was biased towards age and gender as of the majority participants were female and over the age of thirty. Reflexivity was also an essential concern when considering my position from an ethnographic perspective.



Ethnographers are generally located as either 'insiders' or 'outsiders' to the group they are researching (Allen 2004; Bonner and Tohurst 2002:8; Hammersley and Atkinson 1995). Researchers are 'insiders' when they are part of, or share similarities with the social group they are studying, whereas the term 'outsiders' refers to those who are external to the studied group (Dwyer and Buckle 2009:54). My position was notable as it represented neither an absolute insider nor outsider position, but rather I hold a point within a continuum that linked the two perspectives (Merton 1972). I was located as what Spradley (1980:58) terms, a 'moderate participant'; situated approximately mid-way on a continuum between being a 'complete (...) and non-participant'. This position was determined by a lack of registration to practice as a nurse, and as such, an inability to completely participate in the activities of CCN culture. This standpoint enabled a medium-low degree of involvement in the activities of the group. Possession of some understanding of the actions, language, rituals and artefacts of their practice enabled me to assist in tasks that included bed-making, fetching of equipment required by CCNs', and restocking, and this proximity enabled me to interact with participants, and thus co-construct meaning.

Therefore as a researcher, I was located in a non-dichotomous position that combined insider and outsider perspectives which Dwyer and Buckle (2009:60) term 'the space between'. For example, my previous working life as an Enrolled Nurse in the areas of Anaesthesia and General Practice located me as an insider with some understanding of nursing culture (Allen 2004; Bonner and Tohurst 2002). On the other hand, being an Enrolled Nurse, rather than a Registered Nurse, my lack of experience in critical care nursing, and unfamiliarity with the group of CCNs, firmly placed me as an outsider, and thus, I doubted my ability to achieve rapport with the CCNs (Allen 2004; Bonner and Tohurst 2002).

As I considered my status as a one-time Enrolled Nurse below CCNs within the nursing hierarchy would exclude my membership to the CCN group, I believed CCNs may also share this thinking. This was overcome by my open disclosure of previous nursing experience, but lack of specification this was as an Enrolled Nurse. While this resulted in me feeling somewhat like an imposter, I perceived this strategy increased credibility with the CCNs, and this was crucial to achieve rapport and promote their honesty. If any of the participants had enquired to my nursing status directly, I was prepared to clarify the specifics of my Enrolled Nurse certification. While there was a risk this may have then

excluded me from the group, I observed total honesty in such an instance was required. When CCNs inquired to my area of speciality, I elaborated truthfully, however, at no time was I asked the specifics of my accreditation.

Being in 'the space between' empowered me to balance the positive and negative aspects of both insider and outsider perspectives, and thus I attempted to overcome the limitations of being confined to either position (Dwyer and Buckle 2009:60). Creswell (1989: 93-95 in Gobo 2008) suggests insider knowledge contributes to a more profound and extensive understanding of a particular social group, and this promotes ease of access to the field, or what he terms 'getting in' and 'getting on'. (These concepts are also discussed on page 97 under the subheading 'Sampling).

Nursing experience enhanced my credibility among nurses; it was advantageous in negotiating access to the hospital with the Director of Nursing, and to the ICU with the Nursing Unit Manager ('getting in').

My knowledge of nursing culture also guarded against the 'culture shock' of being total unfamiliar with the CCNs, and this helped to focus attention to the topic of interest (Bonner and Tohurst 2002:10). In addition, a degree of cultural knowledge benefitted my acceptance into the group, and

establishment of on-going rapport with participants ('getting on'). This was because my shared similarities endowed me enough awareness of their practice to not frequently hinder their activities for clarification of nursing tasks, as I was aware of appropriate times to pose necessary questions.

My familiarity with some of the language, and many of the clinical tasks within the ICU, enabled me to better understand the fundamentals of what was 'going on' without continuously needing to seek clarification of the tasks being performed. This meant the central focus of the study, meaning-making of professional identity, could be maintained, rather than unsystematically generated irrelevant data. Insider knowledge was further beneficial as it limited any inconvenience to CCNs' normal flow of activities. This minimised researcher presence and thus, increased rapport with participants (Bonner and Tohurst 2002; Creswell 2013). In developing rapport, I aimed to lessen the high degree of possible participant reactivity associated with my full disclosure as a researcher, leading to more open and honest contributions from participants (Hansen 2006).

Previous nursing experience also resulted in some possible limitations for generating data. The most notable of these was limited data generation on

some features of CCNs' working lives. For example, due to trauma witnessed during my nursing work life, the topic of death was avoided throughout the study due to my own sensitivities. Moreover I also believe my previous nursing experience may have resulted in problems with recruiting. This was confirmed by one of my participants who explained that some CCNs may be reluctant to be watched in case their practice is criticised given that I possessed insider knowledge.

There were also potential disadvantages in my familiarity in early stages of the study. As the central interest of the project was eliciting the meanings that participants attached to activities, language, rituals, and artefacts from within their perspective, this necessitated frequent questioning of the CCNs (Gobo 2008). However, recurrent requests for CCNs' clarification in the early stages of data generation potentially challenged the credibility of a researcher claiming insider knowledge (Bonner and Tohurst 2002; Hammersley and Atkinson 1995). I actively sought to minimise this risk by limiting these questions to the final phase of observations and asking specific questions in semi-structured in depth interviews. (How observations and interviews were approached in this study will be detailed later in this chapter).

Insider familiarity was further disadvantageous to generation and analysis of data as there was the possibility that the researcher was unable to go beyond their own taken for granted assumptions (Allen 2004; Bonner and Tohurst 2002). This could have contributed to an inadequate understanding of participants' meanings of symbols, actions, rituals and artefacts (Creswell 2013). However, unfamiliarity with this specific ICU, and the staff within it, meant that I could assume an 'attitude of strangeness' in observing the CCNs as a culture sharing group from a position of unfamiliarity (Neuman 2011:437).

In adopting critical reflectivity to all stages of the study, I attempted to negate any degree of familiarity by maintaining necessary 'distance' from participants (Hansen 2006; Bernard 1995 in Liamputtong and Ezzy 2005:170). This involved balancing between being in close proximity to interact with participants gain insight into their shared meanings while maintaining distance from their personal lives, and issues that were not the focus of the study. Moreover, CCNs assisted in maintaining distance as I was rarely invited to accompany them into the backstage areas of the ICU.

Assuming an attitude of strangeness also minimised the risk of the researcher 'going native', or losing the focus of the study, that is often associated with being an insider (Creswell 2013; Gobo 2008; Hammersley and Atkinson 1995). As I did not fully participate in the activities of the group, I was able to concentrate on observing their performance of routine tasks and accessing meanings attached to them while interacting with CCNs (Brewer 2000; Hammersley and Atkinson 1995). My outsider status also limited any conflict between the role I assumed as researcher, and CCNs' expectations of my role as a nurse (McGarry 2007). For example, tensions did arise between these roles when participants expected my assistance with specific clinical tasks, such as preparing medication. In these instances, I clarified my role with reference to my lack of current nursing accreditation, and therefore retained the focus of data generation.

Despite the disadvantages experienced, the distance offered by 'the space between' was mostly advantageous as it enabled me to remain separate from close involvement in the tasks or processes within the ICU, whilst staying physically proximate to the day to day events, conversations and activities of CCN practice (Brewer 2000). This location facilitated observation of the activities of the ICU in a way that identified alterations in routines between staff members and across temporal dimensions, and

clarification of their the meanings (Bonner and Tohurst 2002). As an outsider, I was additionally unaware of any pre-existing tensions between CCNs, nor was personally obligated to participants (Simmons 2007). Bonner and Tohurst (2002) argue this benefits exploration of participants' life worlds without the associated biases to those that I had personal alliances with, rather than ethical obligations to.

## **Approach**

### **Sampling**

The study utilised a purposive sampling strategy to specifically target individuals and sites based on their relevance to the research question (Creswell 2013). This strategy targeted a fieldsite where CCNs, who possess knowledge of professional identity processes, were accessible. The ICU served as a rich source of data as it is where CCNs practice, and access to the site enabled identification of 'the learned patterns of values, behaviours, beliefs and language' (Harris 1969 in Creswell 2013:90; Silverman 2005) of CCNs from within the context of their workplace. The choice of a single hospital was based on two concerns; first, the practicality of location, and second, it supported comprehensive exploration of participants. Thus, the generation of textured, in-depth, nuanced data was possible (Creswell 2013).



The sample comprised of 13 participants; 10 female and 3 male CCNs, including one CCN from a culturally and linguistically diverse background. However, due to the small sample and issues of confidentiality and anonymity associated with researching a regional area, the gender of the culturally diverse CCN was not disclosed. Table 2 (following page) sets out sample characteristics of the CCNs including Grade of employment, years of experience and postgraduate qualification.

Participants were allocated to one of four roles (with the exception of day shift and night shift) within the ICU; In-Charge (CCNIC), Float, Access, and TPC (Total Patient Care). While the majority of participants rotated through these roles (Brenda, Indiana, Karla, Hallam, Marcus, Airlee and Catrina), the others were allocated only to TCP. These roles are set out in Table 3 (page 100). Participants were rostered to one of three shifts; early, late and night. All CCNs' were required to rotate between shifts each month. Therefore, staff who predominately worked early and late shifts were rostered to night shift for eight days out of twenty eight (an average of two shifts out of seven). Similarly, permanent night staff worked the same proportion of early and late shifts.

Groups	CCNs	Training	Postgraduate qualification	Employment Grade
Most experienced 20 years or more	Brenda	University	Yes	Grade 4
	Gaynor	Hospital	Yes	Grade 3
	Indiana	University	Yes	Grade 4
Moderately experienced 11-19 years	Karla	University	Yes	Grade 3
	Hallam	University	Yes	Grade 4
	Marcus	University	No	Grade 3
	Airlee	University	Yes	Grade 4
	Donna	Hospital	Currently undertaking	Grade 3
Less experienced 10 years or less	Fern	University	Yes	Grade 3
	Penny	University	Yes	Grade 3
	Nina	University	No	Grade 3
	Catrina	University	Yes	Grade 3

**Table 2: Sample characteristics**

The early shift was the busiest in terms of numbers of staff and activities. Staff included CCNs, nursing management, medical staff, administrative and support staff. If the unit was at full capacity, there were eleven or twelve CCNs on duty; when not at capacity, CCNs were often redeployed to busier wards within the hospital. Nursing administration in the ICU during the early shift included the Nurse Educator, (who kept the same

hours as the early shift CCNs), and the Nursing Unit Manager who attended from 9am-5pm.

<b>In Charge (CCNIC)</b>	<b>Float CCN</b>	<b>Access CCN</b>	<b>TPC</b>
<u>Shifts</u> Covers outside NUM's hours on early shift. Late shift Night shift	<u>Shifts</u> Early shift Late shift Combined with CCNIC on Night shift	<u>Shifts</u> All shifts	<u>Shifts</u> All shifts
<u>Duties</u> Coordination of staff coverage  Attending rounds  Liaising with medical staff/ patients' families  Coordinating meal breaks  Coordinating patient transfers  Necessary paperwork	<u>Duties</u> Assisting TPC CCNs when required  Relieving for meal breaks  Necessary paperwork	<u>Duties</u> Attending emergencies outside the ICU as part of the MET (medical emergency team).  Relieving for meal breaks  Assisting TPC CCNs if needed  Necessary paperwork	<u>Duties</u> Attending to patient care  Attending rounds of allocated patients  Liaising with patients' families  Necessary paperwork

**Table 3: CCN roles in the ICU**

Medical staff typically numbered up to eight doctors, particularly on the daily 8am ward round, when all four level of medical officers (Interns, Resident Medical Officers, Registrars and Consultants) attended with a

physiotherapist, pharmacist and social worker. Morning Rounds involved decisions regarding changes in treatment orders and patients' impending discharge from the unit. CCNs managed these changes as well as providing full personal care and performing the routine tasks of observations, medications, and management of technology associated with their patients. Allied health professionals including physiotherapists, radiographers and pharmacists also made daily rounds just before the 8am round to ascertain the activities of the working day, and to attend to daily chest x-rays and medication changes.

Late shifts lacked nursing management staff and a CCN was allocated to the nursing In-Charge role. Medical staff was limited to two or three doctors until 10pm, and a medical round was conducted at approximately 4pm and 7pm, as medical staff on the early and late shift handover to the night shift Registrar. Allied health staff were 'on-call'. Administrative and domestic support staff were minimal; the CCN In-Charge attended to the majority of paperwork, and the Access CCN helped with such tasks as emptying garbage bins and stocking linen. A central feature of the late shift was the attendance of patients' visitors, and as such, only necessary clinical work was performed during visiting hours.

The night shift had no support staff and a single doctor (who generally slept from midnight to 5am, if possible). Only necessary work activities were performed and CCNs used their spare time to attend to activities not related to work, such as transcribing data for postgraduate research projects, working on postgraduate assignments, or marking assignments from casual appointments with the local university.

The researcher negotiated access to the ICU on three levels:

1. A meeting with the Director of Nursing at the hospital explained the project and confirmed ethics approval.
2. A meeting with the Nursing Unit Manager and Nurse Educator of the ICU further elaborated on details and purpose of study, and conditions of access were negotiated. At this time, flyers (see Appendix 2 FLYER) promoting the study were left, and these were displayed in appropriate locations around the ICU.
3. A group meeting with CCNs conveyed the purpose and methods of the study. At this meeting, Participant Information sheets (see Appendix 3: INFORMATION SHEET) containing the researcher's contact details, and Consent Forms (see Appendix 4: CONSENT FORM) were distributed to all attendees.

The ICU provided access to 40-45 CCNs as potential participants. CCNs were encouraged to contact the researcher via email to express their interest in participating in the study. When potential participants made contact, the researcher forwarded Participant Information and Consent Forms via return email if required. In addition, the researcher requested CCNs to suggest a suitable time at which observation could occur. The study was further promoted to CCNs unaware of it during observations, with the aim of recruiting further participants. I sought to recruit participants based on practice experience, level of employment, post-graduate qualifications, gender and ethnicity, as these were deemed important characteristics in terms of including participants with a range of experiences, however, I was limited to those specific at the site, which meant that I could not gain diversity in all aspects.

The researcher gained physical access or, 'got in' to the ICU with ease, yet the establishment of social access, or 'getting on' and engaging with participants once inside the ICU was more challenging (Creswell 1988: 93-95 in Gobo 2008). The NUM of the ICU initially promoted social access through displaying flyers, and organising a meeting to discuss it with CCNs, however, my access to the ICU was conditional on no further provision of assistance in recruitment. Low recruitment was a constant

concern throughout data collection, and was related to issues of social access and my own nursing knowledge. While the number of participants in a non-random sample is not a concern within qualitative research in the same way as it is in the random sampling of quantitative approaches (Cresswell 2013) , I estimated an ideal sample would be at least fifteen.

While initial recruiting began early after physical access to the unit was granted, it proceeded at an exceedingly slow rate. Three months into the study, and the sample had expanded to ten, but three participants had left the study due to their decisions to leave the ICU. After five months, I conducted a second wave of recruiting, and met with CCNs who may have been unaware of the study due to being on leave when it commenced, with the hope of attracting them to participate, and this resulted in one extra participant.

When I reflected on the possible reason for the low levels of recruitment, I believe there were a number. In identifying these, I acknowledge my best efforts to overcome the challenges they presented. During observations, the NUM maintained distance from me, and this hindered CCNs' acceptance of my presence and the project. Moreover, I suspected the NUM's distance heightened CCNs' suspicions of me, and the aims of the study. This was demonstrated in initial observations when CCNs went to

practical lengths to avoid me; walking an extended distance around the ICU, rather than passing by me, and avoiding eye contact. In addition, CCNs not involved as participants lowered their voices to speak to one another when I was nearby. To counteract the NUM's distance and CCNs' suspicions, I greeted all staff upon my arrival at the unit, and moved away from CCNs' lowered conversations when they arose.

Social access was also restricted by the removal of flyers early in the study, and the conditions of entry to the ICU. Access had been granted on the condition that my attendance was restricted to occasions when observing a nominated CCN. This meant my ability to promote the study through simply "being there" was limited. When this was coupled with the removal of flyers, low recruitment rates were explained by CCNs' lack of knowledge of the project. I sought to maximise social access to CCNs through promoting the study by enagaging in a practice that was common among medical staff; supplying snack food. I placed my provisions alongside the variety supplied by medical staff and positioned myself nearby with Participant Information, and Consent forms. As CCNs approached, I conversed with them about the study. If they indicated interest, Information and Consent Forms were provided for their consideration. The success of this strategy was demonstrated in



CCNs' discussions about the project between themselves in the initial weeks of observations.

## **Methods**

In keeping with a social constructionist epistemology, data were generated from eight semi-structured in-depth interviews and ninety-two hours' of participant observation. Employment of two sources of data offered a more comprehensive research design than the adoption of a single one source of data. This allowed a more complete grasp the complexity of professional identity from inside the social perspectives of CCNs through comparing data and identifying contradictions and consistencies (Fetterman 1989). Reflexive practice supported interpretation of these as related to possible participant reactivity and issues of intersubjectivity, or participants telling me only what they thought I wanted to hear (Hammersley and Atkinson 1995; Liamputtong and Ezzy 2005).

## **Interviews**

Interviews were a vital method as they enabled description and interpretation of CCNs' meanings from an *emic* perspective (Fetterman 1989). The adoption of semi-structured in-depth interviews facilitated focus on the dynamic processes of CCNs' construction, reconstruction and negotiation of their professional identities. As such, interviews allowed

exploration of the meanings CCNs attached to their actions, language, rituals and work objects from within the context of their social realities, and this informed insightful understanding of professional identity from inside their 'life worlds' (Liamputtong and Ezzy 2005; Schutz and Luckmann 1973).

Semi-structured in-depth interviews focused on discussing significant topics arising from observations. Conducting semi-structured in-depth interviews generated data on CCNs' subjective understandings of their professional identities (Silverman 2005). This form of interview is in contrast to structured interviews or surveys in which specific questions are inflexible and sequenced. Rather, interviews were directed by an interview guide that included open and closed questions to encourage participants' consideration and elaboration on answers. Interviews were loosely structured and topics for discussion were set out on an interview guide (see Appendix 1 INTERVIEW GUIDE) that provided direction, rather than strict structure and sequence. Participants expanded on their answers through conversation, as questions were constructed spontaneously, and CCNs raised topics and issues they regarded as significant. In so doing, CCNs' meanings were elicited through active co-construction, clarification and negation with participants (Patton 2002;

Silverman 2005). Topics covered during semi- structured in-depth interviews included:

- participants' nursing training;
- nursing experience and other specialties;
- postgraduate study;
- perceptions of professional identity;
- employment levels;
- shared meanings;
- activities of work;
- gendered differences; and
- the ideal CCN.

Interviews were beneficial in providing the flexibility compatible with the non-linear nature of ethnography as they facilitated development of questions in response to data that emerged from observations (Gobo 2008).

Interviews were conducted away from the ICU; six of the eight semi-structured in-depth interviews occurred in a private office within the hospital. One interview was conducted at a private office at the university and, one in the break room of the ICU while a night shift CCN was on a scheduled break. Interviews ranged in length, with the longest lasting fifty-eight minutes and the shortest being twenty-six minutes. All CCNs

consented to the recording of interviews with a digital recorder and interviews were transcribed as soon as possible after occurring.

Transcription was verbatim and included all utterances with the aim of capturing CCNs' nuanced and complex understandings. All participants were offered individual interview transcripts to review so that they could clarify, amend, or elaborate upon their answers. This process of 'member checking' was important in contributing to credibility within this study (Denzin and Lincoln 2008; Lincoln and Guba 1985). Three participants agreed to have their transcripts emailed to their staff email accounts, however, only one transcript was returned with clarifications.

### **Participant observation**

Data were additionally generated from the core ethnographic method of participant observation (Neumann 2011). Participant observation involved the researcher entering CCNs' natural workplace setting of the ICU to establish direct relationships and participate in their culture sharing group (Creswell 2013). Observations focused on CCNs' everyday work actions, use of language, rituals, and application of artefacts. This included their delivery of patient care, performance of clinical tasks, interactions with nurses, patient, families and other health professionals and significant events such as nursing handover and ward rounds.

Participant observation was conducted for ninety-two hours over a seven month period, and central elements included (Fetterman 1989; Hammersley and Atkinson 1995):

- Being present in the ICU;
- Observing CCNs' interactions with other staff as they performed daily activities of their work within the ICU;
- Describing the ICU as CCNs' work setting; and
- Asking CCNs questions to understand how things worked within the ICU.

With this focus, I became immersed in the day-to-day working lives of CCNs and elicited what Geertz (1973:5) terms 'thick descriptions' of their common meaning making processes.

Observations occurred during forty-five visits to the ICU between November 2013 and June 2014, and included the three different shifts of nursing staff. This comprised of thirty hours of the early shift (7am-3.30pm), thirty-two hours of the late shift (2pm -10.30pm) and thirty hours of the night shift (10pm-7.30am). Conducting observations across the three shifts attempted to maximise the number of potential participants by

including permanent night shift staff, who may not have been recruited otherwise. In addition, it contributed to identification of the differences in the temporal dimensions of each shift. This not only informed contextual understandings of the ICU as a whole, but also in terms of comparative analysis between the separate shifts within it.

The researcher directed attention to observing particular participants as they interacted within the regular comings and goings of the ICU. On occasions when more than one participant was present in the ICU, each CCN was observed separately and interactions between them were noted. The length of observations varied; the longest was three hours and thirty minutes and the shortest was thirty minutes, with the average being approximately two hours. The length of time spent observing each participant overall differed; the longest being ten hours and thirty minutes, and the shortest being one hour and twenty minutes, with an average of seven hours. These hours enabled observation of each participant across each shift and their interactions with patients, Allied health professionals, medical officers, patients, family members and other CCNs.

Observations involved three phases. The initial phase encompassed 'ghosting', or 'shadowing', participants. This focused on describing both the environment of the ICU, and CCNs' work activities to find out "how things worked" in the ICU, and identifying common patterns of language, artefact use and actions. McDonald (2005) describes shadowing as a technique involving the researcher closely following a member of staff over an extended period and asking questions to prompt a running commentary with the person being shadowed. The presence of ten second year nursing students in the unit during the first ten weeks of observations was serendipitous for shadowing, as their interactions with CCNs incorporated a considerable amount of overt knowledge exchange regarding the meanings of their actions, language, work equipment, or results of medical tests. Examples of this included Catrina asking her nursing student of the requirements of hourly observations (Chapter Five, 'The Centrality of Knowledges'), and when Edwin explained the protocol for discharge from the ICU to his student (Chapter Five, 'The Centrality of Knowledges'). As such, I could focus on descriptive questions about general activities within the unit. Examples of these questions included, 'What times do the attendants make their rounds?' when I observed their regular attendance to the unit, and 'What is the shift log for?' when Catrina explained that she was filling in the shift log.

The second phase of observation covered shadowing participants while specifically focusing on their interactions with:

- Patients (when CCNs performed clinical tasks such as patient assessments, delivery of medication and wound treatment and maintenance);
- Medical officers, as they carried out rounds and addressed identified medical concerns;
- Allied Health professionals, such as physiotherapists and radiographers, as they made their daily rounds and engaged in collaboration;
- Other CCNs, including those assigned to the In-Charge, Access and Float roles, as these roles co-ordinated tasks and meal breaks, worked collaboratively with and sought clinical information from CCNs; and
- Patients' family members and visitors, as CCNs provided information and reassurance to them.

During the second phase of observations, researcher familiarity with the routine of the unit enabled attendance at particular times so as to coincide with specific events. These included medical rounds across all shifts, the



morning rounds of the physiotherapists, radiographers and pharmacists, and nursing handovers on the early and late shifts. Medical rounds and nursing handovers were events of particular interest as they afforded opportunities to observe CCNs' interactions between other CCNs (in the case of handover), and medical officers and Allied health professionals (in the case of medical rounds).

The third phase of observations continued attention to CCNs' interactions, but also incorporated asking focused questions that were specific to observations. The considerable degree of rapport I had with participants by this stage enabled asking questions that I felt may have reduced my credibility if asked earlier in observations. Examples of the questions asked were, 'Can you tell me why you are doing that?' as Karla was performing a clinical task (Chapter Four, 'Multiple Constructions of Professional Identity') and, 'How did you know something was wrong?' when Indiana responded to a medical emergency (Chapter Five, 'The Centrality of Knowledges').

### *Fieldnotes*

All phases of the observation were recorded in 'intense and involved' fieldnotes (Emerson et. al. 1995 in Liamputtong and Ezzy 2005: 171).

Fieldnotes were recorded overtly in a notepad and included drawn maps of the unit, descriptions of observations, notes from focused questions during observations, including my own reflections of them. In keeping field notes, I captured thorough descriptions of CCNs' meaning-making so that later stages of analysis did not have to rely on memory (Neuman 2011).

During the first phase of observations, field notes initially focused on describing the ICU. In addition, I made descriptive notes of the clinical tasks CCN undertook and the equipment they utilised. I did this to become familiar with the routine of the ICU through identifying common patterns of activity. The second phase shifted to record each participant's interactions with other CCNs, medical officers, patients and their visitors and Allied health professionals to observe their meaning-making of professional identity. Field notes also included descriptive details of the ICU during observations, such as the number of staff and patients present, as these were significant to the context of CCN practice on each occasion. In addition, coded information that described patients' conditions was recorded for the same reason. This comprised of whether a patient was:

- Intubated;
- Being ventilated;

- Having renal dialysis;
- A post-operative admission; or
- A high dependency patient.

Details of the beginning and ending time of observations, as well as the timing of interactions, descriptions, and CCNs work tasks were also recorded in fieldnotes.

Field notes were transcribed in full detail on a daily basis. As I transcribed, I reflected on observations and my accompanying emotional responses. This allowed interpretation of both participants' meaning -making as well as my own experience as a researcher (Creswell 2013). Daily transcription represented initial analysis as it identified patterns of behaviour that became the focus of later stages of fieldwork (Gobo 2008). Transcripts were broken down into separate descriptions of individual interactions, CCNs' performance of clinical tasks and their utilisation of artefacts; these were awarded an alphanumeric code and a pseudonym, so that they could be retrieved during analysis. These codes related to the number of researcher attendances, the specific CCN being observed, and the sequence of interactions within each attendance. For example, the code

CCNB1201 refers to my first observation of Brenda on the twelfth visit to the field site. The time of observations were also recorded on individual transcripts. Transcripts of observations totalled more than five hundred pages, with the shortest being five lines, and the longest being seventeen pages.

### **Analysis**

Observation and interview data were subjected to inductive thematic analysis to enable themes to emerge from the data through reiterative coding (Bryman 2004). In the first level of analysis, transcripts were scrutinised in line-by-line reading while 'open coding' was undertaken. Open coding involved examining data and applying codes. As I was interested in the processes of CCNs' professional identities, codes were in the form of 'gerunds'; verbs that described processes within data. For example, within observation data, the code 'exchanging knowledge' was broadly applied to instances where knowledge was exchanged between CCNs, their students, other health professionals, their patients, or patients' families. This first level of coding enabled data to be broken down into meaningful manageable segments, but more importantly, the identification of significant recurring processes (Charmaz 2014).

Coding of fieldnote transcripts at the first level resulted in seven hundred and ninety-five separate codes. Examples of recurring and significant codes at this first level of analysis included;

- Using clinical knowledge;
- Using technical knowledge;
- Performing legislative requirements;
- Performing procedural requirements; and
- Instructing student.

Codes from first level coding were recorded on a spread sheet, and these were colour coded to distinguish the specific nursing shift in which the observation had occurred. This was done for comparative analysis of differences and similarities between temporal dimensions, and interview data.

Interviews were subjected to similar open coding. First level coding of interview transcripts resulted in three hundred and twenty codes, and examples included;

- Emphasising clinical practice;
- Highlighting knowledge/skills; and
- Using tacit knowledge.

Interviews were additionally colour coded, whereby sections of text that had been awarded the same code were marked with the same colour font, before being electronically recorded.

The first level of coding of both sources of data also encompassed the application of 'in vivo' codes. These were codes that captured terms that participants used commonly within their practice, and these indicate shared meanings (Charmaz 2011). In vivo codes included the names of medications, such as Norad (short for Noradrenaline), names of equipment, such as PCA (Patient Controlled Analgesia), and procedures, such as Trachy (Tracheostomy), and significant codes are listed in the Glossary.

Second level analysis involved focused coding. Observation and interviews transcripts were integrated and re-read for similarities and differences, and significant and recurring codes emerging from first level analysis were applied throughout by comparing, contrasting and amending previously applied codes. This process revealed contradictory and contrasting perceptions both within and between each source of data, and these were counted as noteworthy. The researcher moved reiteratively between each source of data and the literature, and as new information became available, new codes were applied, the transcripts were re-read

and amended, and changes were recorded on the master document. At this stage, categories that connected similar codes were created. For example, the codes identified above (with the exception of 'Using technical knowledge') contributed to the category 'Demonstrating Knowledge', while the remaining code was combined with others to constitute the category of 'Technical Competence'.

The final, interpretive level of analysis represented an incubation process whereby data were interpreted through examination of similarities, contrasts and patterns of themes to generate theoretical explanation (Green et al. 2007). Reiterative movement between data and literature additionally gave theoretical meaning to the emergent themes. In considering the examples on the previous page, both the categories 'Demonstrating Knowledge' and 'Technological Competence' underpinned the theme of 'The Centrality of Knowledge'.

## **Ethics**

The study abided with the National Statement on Ethical Conduct in Human Research (2007) requirements of informed consent, voluntary participation, and confidentiality and anonymity, and was approved by the Tasmanian Health and Medical Human Research Ethics Committee

(Reference Number H0013483). Informed consent and voluntary participation were ensured by the displaying of flyers and circulation of Participant Information sheets in the meetings with the ICU staff (mentioned under the heading Sampling and Recruitment), as this allowed the CCNs to decide on their own accord to be part of the research. The privacy of participants was protected through coding of fieldnotes and interviews as well as the removal of identifying data and application of pseudonyms during transcription.

A central ethical consideration was the study's focus on CCNs interactions. This meant that informed consent was required for not only participants, but also for those individuals whom CCNs interacted with. This included axillary staff, other CCNs, doctors, Allied health professionals, patients and their families. Gaining consent from this large number of individuals moving in and out of the ICU when they were not the focus of the study would have been impractical. As such, I applied for waiver of consent, and this was approved on the basis of inconvenience, and the harm it may have caused to these people, as well as the minimal risk posed by the study.



## **Limitations**

Through exploring and interpreting the meanings that CCNs attach to their professional identities, I responded to both my personal concerns, and academic's interest of the ambiguity surrounding nursing's professional identity. I acknowledge that professional identity is a well-researched phenomenon, however, the value of the findings in this study lies in the new insights it offers into intra-professional boundary work processes within the distinctive work context of a regionally located ICU (Tracey 2010).

The adoption of a qualitative approach for the study meant that I cannot claim the results to be true, valid, objective or generalizable across the population (Creswell 2013). Rather they are representations of my own interpretations of CCNs' subjective understandings of professional identity. As this small scale study focused on one particular group of CCNs in one specific ICU, the findings are generalizable to theories. This is in contrast to populations, and thus, they represent 'moderate generalizations' (Bryman 2004) of CCNs' professional identity processes in alternative settings, such as other regionally based ICUs.

However, the findings were limited in terms of both the size and characteristics of the sample, and the regional location of the study. This has implications when findings are considered in relation to alternative larger field sites, particularly those situated in metropolitan areas. While strategies to maximise the number and variation of participants within the sample, including snowballing and returning to the field to recruit a second wave were adopted, the sample is predominately female and Anglo-Australian. Therefore, findings cannot necessarily be applied to studies of other, specifically metropolitan ICU's, where larger numbers and a higher degree of gender and ethnic variation may be present. Furthermore I acknowledge that the sample is biased in favour of female participants and thus, differences between male and female CCNs' constructions of professional identity are not fully captured.

## **Conclusion**

This chapter has detailed the ethnographic methodology and methods of participant observation and semi-structured in depth interviews that were employed to explore CCNs' professional identities. It argues this an approach and methods enabled me to capture of CCNs' subjective understanding of professional identity within their everyday practice. The advantages and disadvantages of my previous working life as an Enrolled

Nurse, and my position in the space between were identified and strategies to overcome specific adversities were discussed.

The chapter showed how low recruitment was a predominant issues and the specific steps I implemented to overcome this. In addition, I identified my previous working life an Enrolled Nurse and detailed the influence of this in establishing rapport and data generation. Reflexivity was identified as integral to this interpretive based approach, and my own bias and its influence on the entire research was discussed. Finally, the limitations of the study were acknowledged.

The following chapter, 'Multiple Constructions of Professional Identity' begins the presentation of the study's findings by detailing how CCNs perceive their professional identities. It emphasises that CCNs' meanings of professional identity are subjective, and thus they are shaped from within their own socio-cultural positioning. CCNs' meanings of professional identity are explored through three central themes, and these demonstrate their diversity. Moreover, the chapter shows the multidimensionality of CCNs' textured understandings, and how the differences between them are crucial to professional identity construction.

## CHAPTER FOUR

# Multiple constructions of professional identity

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### **Introduction**

In this chapter I explore the CCNs' understandings of professional identity through the meaning making processes that underpin its construction. My analysis exposes that participants share a highly nuanced understanding of their professional identities as informed by their experiences of being nurses and professionals. To understand the processes of meaning-making that underpin CCNs' professional identities I explore their perceptions and performances through four central themes:

- The challenge of definition;
- Professional identity as a subjective experience;
- Professional identity informed by nursing's professionalism; and
- Professional identity informed by the role of nursing.

In addressing each theme, I demonstrate that participants' professional identities are subjective. As such, the CCNs construct their professional identities through an array of meanings. The differences in CCNs'

constructions of their professional identities are important as they challenge the strength of shared identity, thus revealing the possibility of weak cohesion between them and fragility of group solidarity. The divergence in CCNs' perceptions of their professional identities has a likely impact not only professional identity construction, but also worker satisfaction achievement of collective aims, given that group cohesion is a positive influence on these.

In this chapter, professional identity is defined by the participants.

According to the CCNs, professional identity is a perception of oneself that arises from belonging to the nursing profession and performing the role of a nurse. From this perspective, professional identity incorporates a sense of similar actions, language, 'attitudes, values, knowledge, beliefs and skills' that are informed by the contrasting role of nursing and its professionalism compared to other professions (Beddoe 2013:27; Jenkins 2014). Such an understanding emphasises professional identity emerges as a social process by means of interactions between:

- Individual nurses;
- The nursing profession;
- Other health professions;
- Employing organisations;

- Professional regulative bodies;
- Legislative bodies; and
- The broader public.

The chapter begins by highlighting informants' difficulty in articulating professional identity before elaborating on the divergence and diffusion of meanings. The CCNs possess different level of experience. The less experienced CCNs have less than 10 years' experience, the moderately experienced have 10-20 years' experience, while the most experienced have more than 20 years' experience. These are noted in Table----(page number in methodology chapter).

### **The challenge of definition**

During the interviews, the CCNs found it challenging to offer an account of their perceptions of professional identities. For example, their initial responses reflect some confusion before they explored it more elaborately.

Moderately experienced CCNs provided vague answers such as:

*Professional identity is [pause], it's an interesting topic but not many people actually think about it. You know as soon as you say that word [sic]; people are like I've got no idea (Karla).*

Here Karla is indicating not only her uncertainty as to what professional identity is, but she also is connecting to her professional networks through her reference to 'people'. Thus, she indicates a shared ambiguity.

Less experienced CCNs were also challenged to provide a definitive understanding: 'Um [pause] I don't know just how you um, how you um...I don't know' (Catrina).

These two examples reflect a lack of clarity in participants' understandings of their professional identities. This can be interpreted in two ways: first, it raises questions as to the importance of professional identity to CCNs within their everyday practice, and second, the CCNs' unfamiliarity with such a technical term. The uncertainty of the term, and lack of values attached to it were evidenced in first stage observation of Catrina, a less experienced CCN, who was discussing professional identity with Brenda (a most experienced CCN):

*Catrina and Brenda sit checking their emails as they discuss the study. Brenda says 'It is about professional identity.' Catrina laughs out loud and slaps Brenda on the shoulder, 'Professional identity; I don't know how much of that she'll [researcher] will see in here'! Brenda laughs. (CCN301).*

One way that participants from all groups negotiate their confusion of professional identity is to discuss its broadness.

to a scope of meaning. Nina, a less experienced CCN, does this when she comments, 'It's a very broad question isn't it?' This can be contrasted with the moderately and most experienced CCNs, who note the complexity of their professional identities while alluding to its broadness:

*Professional identity...it's basically...means certain things; there are too many aspects to this (Marcus).*

*It's very broad; professional identity because it involves basically everything I've said and... (Brenda).*

These two examples reveal that CCNs' perceptions of their professional identities are multidimensional, as well as differences in understandings between CCNs of different levels of experience. The most experienced and moderately experienced CCNs perceived the multi-faceted nature of professional identity when compared to less experienced CCNs. These differences, particularly between members of the most experienced and less experienced groups, suggest CCNs' professional identities develop and strengthen through their practice (Deppoliti 2008; MacIntosh 2003; Worthington et al. 2013). This is evident in the following statements from members of the most experienced group:

*So my professional identity has changed drastically over... almost a thirty year long period (Gaynor).*

*You have come from... a beginning and you're evolving into an individual who has... certain obligations...in the medical field' (Brenda).*



These examples provide insight into CCNs' perceptions of their professional identities as a process of development occurring through time. The words 'changed drastically' (Gaynor) and 'evolving' (Brenda) readily convey the CCNs' comprehensions of their professional identities are not static. Rather, professional identity is a dynamic aspect of their subjectivities that arise from, and continue through, nursing practice (Benner 1982; Deppoliti 2008; MacIntosh 2003).

### **Personal understandings of professional identity**

All participants said professional identities were their subjective experiences of being a nurse and professional. At one level, professional identity was described in general terms. This is the case when a CCN from the less experienced group explains professional identity as 'how you perceive yourself or put yourself to other people' (Catrina). At another level, professional identity is constructed as an identity that is informed by nursing as a professional career. For example of Catrina further articulated professional identity as:

*The first thing that comes to mind is professional, being... your chosen career, I think; so nursing. And then the identity... I don't know, the identity's a different thing. You know there's heaps of identities; there's what we think we do and... what it entails in our job (Catrina).*

In this passage, professional identity is deconstructed into two components in an attempt to offer a definitive understanding: 'professional' and 'identity'. This approach ties to the perception of being a 'professional' to the commitment of a 'career' in nursing (Johnson et al. 2012). In contrast, Catrina's expression of 'I don't know' highlights the complexity of professional identity. As she initially understood professional identity as 'a different thing' suggests separation between different aspects of identity. The recognition of one's possession of 'heaps of identities' informed by 'what we think we do', is distinguished from professional identity as associated with 'our job'. This emphasises construction of professional identity around specific practices in workplaces (Abbott 1988; Allen 2004; Hughes, Hughes and Deutscher 1958; Willetts and Clarke 2014).

Professional identity is articulated in a more focussed manner when participants discussed their perceptions of being a nurse. This is typified in the following statement from a moderately experienced CCN: 'being a nurse is my professional identity' (Marcus). Participants in the less experienced, and moderately experienced groups additionally express professional identity as how they feel about being a nurse:

*From a personal level, there is a level of pride in being...a Registered Nurse... as a part of your identity in life (Nina).*

*Marcus: I feel proud of being a Registered Nurse... and I feel more proud telling them [other people] I'm a particular Registered Nurse.*

*MJB: A critical care nurse?*

*Marcus: Yes, critical care nurse.*

*MJB: Why do you think that is?*

*Marcus: I feel myself it's something better than, just a nurse.*

These examples demonstrate professional identity is associated with feelings of pride or self-esteem in relation to CCNs own and others' evaluations of them as nurses. In doing so, they suggest professional identity is not simply an aspect of identity that arises from personal elements, such as self-esteem but it is constructed through interactions and subjective evaluation in social contexts (Arthur 1992; Arthur and Randle 2007; Hoeve, Jansen and Roodbol 2013; Öhlén and Segesten 1998). Moreover, the differences in the origin of each CCN's pride are notable. The less experienced Nina associates her self-esteem with being a 'Registered Nurse', whereas the moderately experienced Marcus associates his with the specialty practice of critical care nursing.

The distinction between professional identity as informed by nursing generally and critical care nursing specifically could be associated with the two CCNs' differing length of nursing experience in the ICU, however members of the most experienced group also demonstrate these inconsistencies when associating professional identity with each title. On

the one hand Brenda claims, 'you get it [professional identity] just through being a Registered nurse, it doesn't matter if you're specialised or not'. On the other hand, Gaynor seems to take offence at suggestions that negate her identity as a CCN:

*If they're going to treat me like I'm just a nurse, I'll ram it right up their hum-humm, 'cause I'm an ICU nurse...I'm not just a nurse, I am a specialist (Gaynor).*

The disagreement between participants as to the importance of each title; RN or CCN, reveals a process of differentiating and othering between being a CCN and 'just a nurse'. This process also extends to disagreement between CCNs' ideas on the place of postgraduate study. Moderately experienced Penny, who has postgraduate qualification, finds it acceptable to 'see ourselves as being critical care nurses... even if you haven't done postgraduate qualifications'. This is in opposition to less experienced Nina:

*If you've done extra study you can call yourself a critical care nurse; I haven't, so when anyone asks my occupation I'll say a Registered Nurse'. I don't say Critical Care Nurse (Nina).*

These perceptions are comparable to Marcus' earlier cited self-identification of himself as a 'critical care nurse' despite his not yet undertaking the postgraduate qualification that some CCNs regard as a necessity. More interestingly, in the earlier example of Marcus, he considers his professional identity as a CCN to be superior to other nurses, despite not completing the expected relevant certification while other

moderately experienced CCNs who do possess postgraduate qualification 'don't think being a critical care nurse is any better than being a ward nurse at all; it's just different' (Penny). Consequently, whether being a CCN is a mark of distinction to being an RN varies.

The perceptions of others make an important contribution to the construction of CCNs' professional identities. According to moderately experienced Penny, 'how we fit in, how we work, how others see us at work. [and]... how we are viewed within the community', cumulatively influence how professional identity is constructed. Catrina agrees with this line of thinking: 'there's society and what they think we do and I think there's heaps of views of what...we stand for, or what we do, or...what people think we do' (Catrina). In considering how nursing is viewed by others, participants believe society has a high and positive regard for nurses. For example, Karla stated in her interview:

*Family members trust the nurses more than the medical staff...because for some reason the community as a whole usually sees nursing staff as being... Well, we're the number one most trusted profession in the world (Karla).*

This is telling of CCNs' perceptions of themselves being shaped by the views of nursing held within the community (Hoeve, Jansen and Roodbol 2013). While it is readily recognised that the public regard nurses as highly

trustworthy, the words 'for some reason' are interesting as they convey a lack of definitive reasoning as to why the community holds this belief.

The construction of professional identity as a perception of oneself is also evident in more experienced CCNs' descriptions of their long held aspirations to be a nurse:

*I wanted to do nursing since I was five and I used cry when my brother dressed up as a nurse, 'cause he was a better nurse than me [slight laugh] (Brenda).*

*Originally the idea was that my mission in life would be community care, or community nurse... I think it was around the 80s when it [nursing] become from a vocation to a career path... so [nursing] was no longer the nun's domain, it was a professional domain (Gaynor).*

These CCNs detail their choices to nurse based on a 'mission in life' and contribution to the 'community', which suggests their altruistic motivations. Moreover, Gaynor makes distinctions between the traditional vocational and contemporary professional models of nursing noting the moral and religious underpinnings of the former. This is achieved by locating nursing in 'the nun's domain' before it moved to the 'professional domain'. This represents notions of a 'vocational calling' (Parsons 1939; Weber, Gerth and Mills 1946), which can be easily compared to Nightingale nursing by which nursing was a calling 'from God' (Godden and Helmstadter 2004; Lundmark 2007:770).

The excerpt from Gaynor suggests distinct differences inform individual choices to nurse, and these are distinguished by the traditional vocational and contemporary professional ideology of nursing, however, the less experienced CCNs did not note such differences. Furthermore, Gaynor and Brenda developed an identity as nurses prior to nursing education and training. This is not surprising, as measurement of professional identity is found to be highest in female students, particularly those for whom nursing is a first career choice (Adams et al. 2006).

What is apparent is the meanings CCNs attach to their professional identities are not limited to personal understandings of identity. Rather, the term has a range of connotations that encompass a number of salient features, including the significance of the professionalisation of nursing.

### **Professional identity informed by nursing's professionalism**

CCNs' construction of professional identity based on the ideology of nursing's professionalism is evident in three subthemes: tertiary education; nursing as a profession; and nursing as an autonomous practice.

Collectively these subthemes work together to achieve professional identity.

## **Tertiary education**

CCNs associate professional identity with nursing's professionalism by identifying the movement of education and training out of hospitals and into the tertiary education sector. This is most often expressed with reference to the undertaking of the Bachelor of Nursing, and CCNs' socialisation into the ideology of nursing's professionalism within it: 'Uni [versity] sort of drummed it into you how you were accountable...under the law for what you're doing... with privacy, with giving out drugs, with evidence based practice' (Nina).

Nina highlights that the degree of meaning attached to professional identity is not only informed by the curriculum of the Bachelor of Nursing, but how the Degree content and teaching emphasise individual accountability as fundamental to professionalism. What is notable is that while participants observe themselves as being accountable, this is often directed towards medical practitioners and the use of pharmaceuticals:

*The CCN allocated to bed 4 calls to Brenda, 'do you know what strength this Mg should be?' The CCN points at a 100ml IV flask, 'is it 10 in 100ml or 20 in 100mls?' Brenda peers at the flask, picks it up and says, 'I'll ask'. Brenda approaches the MO in the OA. She returns and announces, 'I asked [MO's first name] and he said 10 should be alright (CCNB 2706).*



Here, individual accountability is observed as being a significant mechanism of socialisation into nursing's ideology of professionalism.

CCNs who have completed the degree believe those not attending university are limited in this regard. For example, it is noted that:

*I don't know if some people actually even see nursing as a profession, especially some of the older nurses; those that were hospital trained ... 'cause it wasn't spoken of as a profession back then... The younger people who go through university they definitely see it as a profession... but I think for some it's... it's more difficult to actually see it as a profession (Karla).*

This passage shows Karla is aware of differences in the professional identities of CCNs. That is, CCNs who have Bachelor of Nursing accreditation have been educated on and into professionalism which contrasts to those who do not have this qualification. Distinctions between the two forms of training are generally made by moderately and less experienced CCNs, but these distinctions are often disregarded by those in the most experienced group, particularly participants who trained within the hospital-based system. These more experienced CCNs deem their lack of exposure to an ideology of professionalism within the Bachelor of Nursing has little consequence on either the manner in which they practice or their capabilities. For example:

*It was always the Certificate [of Nursing] versus the Bachelor [of Nursing] got shoved down your throat... and like I've been nursing for ten years, you now gonna tell me it's gotta be two years just so I can wave a piece of paper*

*round. I can outrun most of my colleagues... and you guys [sic] [other nurses] come to me 'cause I'm user friendly (Gaynor).*

Here, a more experienced CCN emphasises her capabilities with mention of the presumed differences between hospital-trained nurses with a Certificate of Nursing, and university trained nurses with a Bachelor of Nursing. The perception of the Bachelor of Nursing as valued as the only acceptable means of accreditation by either nursing generally, or by individual nurses specifically, is challenged on the grounds of a decades' nursing experience. Gaynor regards the Bachelor of Nursing as a 'piece of paper' in the context of her proven nursing capabilities, and thus she suggests this qualification makes a minimal contribution to professional identity. Consequently, the contribution of the Bachelor of Nursing to nursing's professional status is considered important aspect of professional identity by moderately and less experienced CCNs, however, it is not applicable to all CCNs, particularly those in the more experienced group. For these latter CCNs, practice experience is a more salient feature than the type of nursing studies undertaken.

It is interesting to note that while particular CCNs within the more experienced group disregard the importance of the Bachelor of Nursing to their professional identities, they also offer contradictory statements on the value of tertiary education. This is the case with Gaynor when she

contradicts herself when expanding on the significance of university to her construction of professional identity:

*You're not much of a nurse if you're Certificate trained, to the fact I was just a pleb nurse...it would have been my fifteenth, my seventeenth year, I did my first uni [versity] course. So for me that was developing professional identity (Gaynor).*

Gaynor's choice of the term 'pleb', the shortened form of the word Latin 'plebeian', defines an individual within the lower social class. As a result, hospital trained CCNs are constructed as inferior. While there is no explicit reference to CCNs with Bachelor of Nursing degrees, the reference is relational, and the presence of a superior group of CCNs creates a hierarchy. The perception of being as a 'just a pleb nurse', in contrast to 'developing professional identity' through theoretical education at university, supports the presence of a knowledge hierarchy within Critical Care Nursing, and it is the differences between knowledges that inform professional identity processes. It is also notable for describing the importance of university as Gaynor recognises tertiary education as making a significant contribution to development of her professional identity. The prioritisation of tertiary studies, as well as her extensive years of practice, suggests that both are salient in her construction of professional identity (Arreciado Marañón and Isla Pera 2015; Gregg and Magilvy 2001). What is more interesting is Gaynor awards a high degree

of value to attending university as an aspect of her professional identity, despite the lack of value she awarded to the Bachelor of Nursing in her earlier quote. This indicates that while less and moderately experienced CCNs regard the Bachelor of Nursing as fundamental to professional identity, nursing experience and tertiary education may both have considerable influence on more experienced CCNs' professional identities

### **Nursing as a profession**

The second way professional identity is related to nursing's professionalism is through the participants connecting nursing and its professional status. For example:

*When you say professional, I say like more the profession; probably the nursing side of it [professional identity] (Catrina).*

*[Professional identity is] How us as nurses view our... professional life... how we view ourselves as professionals; that's how I see it...and how we... fit in to our workplace (Penny).*

These extracts illustrate how participants readily acknowledge the professional status of nursing as being central to their experiences of professional identity. They are notable as utilisation of the words 'us' 'we' and 'our', captures construction of professional identity at the collective, rather than at the individual level of nursing (Wiles 2013).

The relationship between professional identity and the collective of the nursing profession is common across all groups of CCNs, and this links them together as a cohesive whole. The professional status of nursing is also explained through reference to specific characteristics, such as in the cases of Brenda and Nina:

*To have the knowledge base and... for the community have a professional identity as such to care, for want of a better term, for sick individuals, or people who need guidance for future health reasons... But professional itself...apart from...every year we sign an AHPRA [Australian Health Practitioners Regulatory Agency] regulation saying we'll do this and this and this; that's trying to make us all more, well I feel... apart from re-assuring... our development...it gives us the identity that we need to maintain our professional ability. And professional identity also entails things like confidentiality, and other ethical aspects of it (Brenda).*

*Along with professional identity comes, there's...a work ethic, and a code of practice that we adhere to, and... standards that we adhere to and I guess when you say professional identity that sort of springs to mind as well; you know with the Code of Conduct. So, there's three different ones I think, that we adhere to.... one's about ethics. There's one more too...That might be just the legal framework within which we work (Nina).*

In these excerpts, Brenda and Nina articulate nursing as possessing a number of features they perceive as characterising professions. These include the possession of a 'knowledge base', a community sanction, a legislative framework, a regulatory apparatus (Australian Health Professional Regulation Agency, and established Codes of Conduct and ethical frameworks (Greenwood 1957; Macdonald 1995).

There are also differences in these the examples. While the less experienced Nina identifies the regulatory frameworks and Codes of Conduct that inform her professional identity, she has difficulty specifying the number of Codes and relevant legislative Acts. This is an indication that Nina is less knowledgeable of the particular titles of the Acts that constitute the overarching legislative framework associated with her practice. Alternatively, these may not contribute to her professional identity, or she does not understand their significance. Although the more experienced Brenda does not identify the titles of the particular legislation associated with ethics and confidentiality, she makes a connection between professional identity and nursing as a profession through referring to registration to a national self-regulated professional body that is essential to practice. In identifying the Australian Health Practitioner's Regulatory Agency, the legislative and regulatory aspects of nursing are seen as an important contribution to professional identity.

In understanding the legal and ethical framework that supports professional nursing practice, CCNs are also required to understand its practical application to their everyday activities. This includes protecting patient privacy and confidentiality. In the passage below, a CCN abides by the Nursing and Midwifery Board of Australia's (2006) Code of Ethics to maintain patient privacy as she qualifies not only the caller's relationship

with her patient, but additionally gains her patient's consent for her to speak to with the alleged relative:

*Catrina walks over to bed 9 carrying the portable telephone. She stands at the end of the bed as she asks her patient, 'Do you have a sister?' The patient replies that she does, and Catrina asks 'what's her name and where does she live'. The patient tells Catrina her sister's name and where she lives. Catrina nods and dials a number as she says, 'she called earlier; I'm calling her back now' (CCNC 502).*

Having knowledge of the legal framework of professional practice extends to understanding these requirements for application in everyday practice.

One of the ways that this is demonstrated is when informants ensure legislative requirements are met by other health professionals, particularly medical officers. In the following example, a CCN organises pathology request forms for his patient's blood to be cultured for bacterial identification in line with established legislation:

*Hallam places two bottles containing a blood sample on the overbed table. He opens the patient's notes to the first page and initials the bottom corner of two computer labels. He peels them off the backing sheet and wraps each around the neck of the specimen bottle. He initials the bottom of the already applied computer label attached to the pathology form as he comments, 'it's a legal requirement that all the labels be initialled to confirm the patient's identity' (CCNH1904).*

Here, Hallam identifies and attends to the legal requirements of nursing practice that inform him the specimen will not be processed unless the paperwork is complete as required. Hallam's knowledge of the legalities

of practice enables him to perform the task on the doctor's behalf, thus preventing delays in the pathology department. In ensuring the legal requirements of the pathology request are met, Hallam facilitates the timely performance of the blood tests within the legislative framework of nursing practice. This indicates the prominence of the legislative aspects of nursing informing CCNs' professional identity and their ability for autonomous practice.

### **Autonomy**

The third subtheme associated with professional identity as based on the professionalism of nursing is autonomy. Participants from all groups explain how autonomy is central to their practice. Less experienced CCN Nina explains:

*In ICU we have a lot of flexibility because... we're monitoring constantly over time. So you can tweak things...so if the doctor's ordered a certain amount of drug... they'll often chart you a 'range' and you decide (Nina).*

Moderately experienced CCN Penny also conveys a perception of autonomy within her practice: 'we can... initiate things... we can initiate different drugs, or initiate things and say something to the doctor and get them to write it down' (Penny). From the more experienced CCNs, Gaynor claims that:



*For me professionally, the good thing [is]...that you're working as a team but you also have a focal point of one patient and what you need to do to tweak them [the patient].... to actually initiate when that [interventions] starts, stops, starts; the setting... although that is actually prescribed by a physician, so often it is directed by the nursing staff (Gaynor).*

These passages illustrate participants possess the capability to practice in a 'self-determined manner' (Varjus, Suominen and Leino-Kilpi 2003:32), and thus, regard professional autonomy to be integral to the everyday practice that informs their professional identities. As a result, they are empowered to 'initiate and 'tweak' interventions. Furthermore, they demonstrate that CCNs acknowledge the limits of decision-making within their practice. This suggests that while CCNs' professional identities may be constructed around their ability for autonomous practice, this also includes recognising boundaries between themselves and the medical profession. In so doing, the CCNs demarcate the jurisdictions of themselves and other health professions in what they will, and will not do.

The boundaries of CCNs' autonomy can also be established by members of the medical profession. This is the case when a less experienced CCN informs the MO that her patient is in Asystole (a malignant heart rhythm) during a late shift. While the actual verbal exchange is inaudible, the CCNs and the MO's body language are telling of their disagreement:

*Catrina peers at the monitor...a concerned look crosses her face... she pulls a printout of the patient's heart rhythm from the printer and looks intently at it. She approaches the seated MO and thrusts the printout towards him as she stands over him...He gives her a disinterested look as he flicks through it. They talk inaudibly as Catrina points to bed 9; the MO shakes his head... thrusts the papers back at her and turns his head away. Catrina snatches them and shakes her head as her body stiffens and she marches back to bed 9 (CCNC402).*

Here, the CCN conveys her concerns to the doctor by drawing on the objective measurements from the monitor as support for initiating medical intervention. The MO, however, disregards her contribution, evidenced by his disinterested look and dismissive wave. Communication differentiates the two professions, and thus it extends beyond verbal language to include body language. While this conflict can be related to gender and status power differentials (Baggs et al. 1999; Henneman, Lee and Cohen 1995; Sweet and Norman 1995), this is not necessarily the case. It is the female CCN who asserts a physically dominant position over the less experienced male doctor, but the power to intervene and act is not hers. So her body language not only demonstrates her demanding of action from the doctor, but also her disgust at the doctor's lack of action. For example her snatching back of the document, stiffening her body, shaking her head and deliberated mode of walking at the end of the interaction, all signify a Catrina's disapproval of the doctor's inaction. Furthermore, the CCN openly expresses her disapproval at the MO's lack of care and accountability to another Registrar on a late shift the next week:

*Catrina nods to the patient and tells the Registrar, 'she went into Asystole on Friday night'. He looks up from the patient's notes, 'yeah, I can see that here. What happened?' Catrina folds her arms across her chest, 'I'm not sure. Her pacemaker just didn't seem to kick in when it should'...The Registrar nods; 'Oh ok. So what did they do for her?' Catrina lowers her voice, 'they did absolutely fucking nothing'; she shakes her head. The Registrar asks 'really?' Catrina goes on, 'yep, nothing. Not a thing. No one cared' (CCNC514).*

When discussing the interaction further during her interview, however,

Catrina conveys a different perspective:

*It wasn't such a big deal... it wasn't like she was there for something else and then went into Asystole. It was a common occurrence, it kept happening with her... They [doctors] were aware of it. I was... covering myself...with a Medical Officer (Catrina).*

This passage indicates professional identity is informed by notions of accountability as mentioned earlier, and this resonates with the National Competencies for Registered Nurses set down by the Nursing and Midwifery Board of Australia (NMBA)(2006). Nevertheless, the CCN's body language during the first interaction and subsequent interaction with the Registrar denote a concern with the patient's treatment, and the immersion of CCNs with their patient's care needs.

Examples of CCN autonomy within their own jurisdiction are evident throughout the study. The next passage describes a CCN's autonomous

decision-making as she engages in the manual adjustment of a patient controlled analgesic machine:

*Catrina picks up the PCA [patient controlled analgesia] machine... Her nursing student asks if the patient is using it and Catrina replies 'I don't think so' and leans over to gaze at the green digital numerical display on the machine as she announces 'Oh, she hasn't used it since 4.16pm... I'll give her another dose now'. She calls out 'has someone got the keys for a second? The CCNIC working in the next bedspace... extends his hand from behind the curtains, holding a set of keys.... Catrina takes them... unlocks the machine...and pushes buttons before she closes it, locks it and returns the keys (CCNC504).*

On this occasion, Catrina uses her professional judgement to manually over-ride the settings in response to her patient's lack of ability or desire to self-administer medication. Thus, she delivers a larger dose than prescribed by the doctor to compensate for the patient's lack of pain relief for what she considers an extended amount of time. In announcing that the patient had not used the machine, and her actions to compensate for this, Catrina justifies her decision to the CCNIC working at the bed beside her. The CCNIC's transfer of the keys denotes one of two things, either his approval or lack of concern with the CCN's autonomous decision-making. Which is correct is irrelevant here. Either or both of these suggest acceptance of autonomous practice as part of professional identity.

More experienced CCNs' observe their autonomy regularly extends beyond their own professional boundaries into the jurisdiction of medical officers. Indiana explains:

*So often we do have doctors who don't have a lot of experience in ICU who really look to you for advice as well... And I think... you do have autonomy in that fact that sometimes you're the only person that knows that and the doctor that's on that night doesn't know that (Indiana).*

The form of autonomy detailed in the passage above is observed in interactions between CCNs and medical professionals:

*Indiana and the Registrar stand beside a patient exhibiting signs of respiratory distress. She looks to the Registrar who has not yet given any medical orders and slowly suggests 'how about we start with a nebuliser and 10mg of morph [morphine]?' The Registrar nods and proposes, 'can we give her some frusi [Furosemide]?' Indiana replies, 'yes but that's not standard in a situation like this'. Indiana organises the drugs and administers them to the patient. Less than a minute later the patient's breathing begins to ease and her O2 saturation levels begin to rise. The Registrar smiles and asks in a relieved tone, 'is it this quick normally? I mean it's like BAM'; he clicks his fingers. Indiana smiles back and says 'yes'. Her tone becomes serious as she repeats 'but frusi is generally not used as a standard resuscitation drug' (CCNI3203).*

Here, Indiana takes control of decisions typically reserved for medical professionals. Despite the Registrar's possession of expert knowledge, and authoritative control of the situation and the CCNs, he is uncertain in his decision-making to assume such control. The CCN, while not granted authority for the ordering of medical interventions, takes authoritative control by offering expert advice to the doctor. In doing so, she engages in autonomous decision making to deliver life- saving medical interventions

in a case where the medical officer is inexperienced or unsure (Bucknall 2003; Hughes 1988; Porter 1991; 1999). This shows CCNs practice autonomously, and highlights how they can exert control in their professional role.

### **Professional identity informed by the professional role**

Professional identity is also expressed through what participants perceive to be the role of a professional. For example:

*It comes down to respect...respect your patient, you respect your colleagues (Nina).*

*Obviously everyone's different so...not everyone is really gonna get on with everybody else, but there's still that line, 'you should be professional' with that other person ...you have to forego your own thoughts... say religious beliefs or any aspects that might estrange you from different people that you meet...and you do have to keep a neutral... tone I suppose with it all because...you have to remain professional (Brenda).*

*It's [professional identity] also the mannerism...in how you conduct yourself, like in being a professional...With that you respect... just being professional person... Minding your manners and your etiquette and all that sort of stuff as well... I think it can be seen both ways; as how you carry yourself and as your chosen role or your profession. I think it's [professional identity]... your attitude, it's your respect to your work colleagues, your patient, your family members; your attitude towards them as well... or [how you] put yourself to other people.... in a respectful manner of all different...walks of life, your old, your young, your different cultural beliefs; that you've got to really stay neutral and just be able to be... to all people. You don't want to offend anyone; you're there to do a professional job really So you've sort of got to be like a mould, you've got to sort of tweak yourself to suit that type of family, or that... culture, or religion that comes with that patient and family that you're looking after (Catrina).*

In these examples, participants' perceptions of their professional identities are connected to specific actions and expectations associated with how they understand the role of a professional. This includes acts of extending 'respect' (Nina; Catrina), being a 'professional' (Brenda), being 'neutral' (Brenda; Catrina) and 'doing a professional job' (Catrina). These characteristics further include: 'how you carry yourself in...the role [of] your profession' and 'being a professional person' (Catrina), including the employment of neutrality, 'manners [and] etiquette' (Catrina; Brenda). Collectively, this suggests CCNs connect their professional identities with characteristics identified by normative understandings of professions (Parsons 1939; 1968). These passages, however, reveal a more dynamic perspective than the static view of professional identity, as it encompasses their patient's 'culture or religion' and humour (Brenda; Catrina). As such, professional identity is a contextually negotiated performance of a specific social role, namely that of a professional (Goffman 1959), which is exhibited through various practice and behaviours.

Participants also speak of professional identity with reference to particular identity signifiers that inform it. The following excerpt epitomises this understanding:

*When I'm at work when I have my uniform on, I'm different. Like I feel like...I don't know. I guess it's safe; you're in a uniform so you have a role...and then you can withdraw at the end, I guess' (Indiana).*

While the statement does imply a degree of ambiguity, it is clear that in this case, a uniform is a marker of the social role that informs this CCN's professional identity. It provides a security of self in performing the professional role, and thus marks the difference between professional identity, and other roles within the private sphere (Goffman 1959; Shaw and Timmons 2010). What is notable is while uniforms are observed as signifiers marking the boundaries between the public and private identities, such distinction is often blurred. Nina explains how:

*Often you hear stories of nurses who are out at the supermarket with a uniform on, and they're jumping on someone's chest because they've had a cardiac arrest. And... it's [professional identity]... more than just being in the workplace (Nina).*

The recognition that one's professional identity has a significant influence on one's actions in spheres outside of their role 'in the workplace' is furthered by Indiana:

*Maybe my [professional] identity has become that way [closely associated with personal identity] because I probably did give so much, like didn't differentiate much between... work and home. And so I have spent a lot of time giving to other people... I mean if I see somebody who needs something. Like when I was at the supermarket and this older lady with a wheelie [walking frame] was watching her taxi go over that way...I did go and find him and get him to come back to her.... you still do have a role; it does apply, it's just different I guess (Indiana).*

This reveals that professional identity is formed around a specific set of social expectations associated with a professional role within, but not



confined to, the context of the work sphere. Moreover, the words 'giving to other people' and the description of providing assistance in the supermarket implicitly refer to the act of caring. Therefore, professional identity overlaps with the personal self.

Caring is the self-identified specialist activity which underpins nursing's claim to professional status, and is frequently incorporated into participants' articulations of professional identity:

*One aspect of it [professional identity] certainly is care... that's certainly one aspect of nursing; ...you do have to care for your patients (Brenda).*

*I have a laid back professional attitude to my work, but in the same respect it [professional identity] is that holistic care in which I was trained, but in a professional manner (Gaynor).*

*I think that we're here to provide the best care that we can, with a high level of expertise and understanding (Karla).*

Here, participants indicate the contribution of caring to their professional identities. Moreover, Brenda speaks of the complexity of professional identity in saying that care is only 'one aspect'. For Gaynor, the priority is placed on holistic care provision within CCNs' professional identities. The reference to the connection between professional identity and care indicates the provision of the latter is significant in her professional identity construction; a value evident in all passages. What is nuanced

about Gaynor's understanding is while she observes 'holistic care' as central to professional identity, her 'laid back professional attitude' is in opposition to normative expectations of the professional role (Parsons 1939; 1968) that CCNs described earlier (see Chapter Two, 'Professionals, Professionalisation and Professional Identity' p. 48 , under the subheading 'Classic sociological approaches', and p. 152 of this chapter).

The acute state of many patients in the ICU means the provision of care takes a number of forms. This includes the performing of full patient hygiene. As ethics considerations prevented the observation of CCNs engaging in activities of an intimate nature, descriptions of hygiene activities are limited, however the following passage describes one aspect of full patient hygiene, namely oral care:

*Karla pulls back the curtains from inside the bedspace...where the patient wears a clean gown and the bed is freshly made. Karla takes a face washer... and wets it. She...leans over the head of the bed and wipes it across the patient's face. The non-communicative patient opens her eyes and watches Karla. Karla talks to her in a quiet gentle voice, 'I'll give your mouth a clean'...Karla pulls large a dampened swab stick from a package and gently inserts into the patient's mouth, working around the ET [Endotracheal tube] hanging from it... She removes the swab stick... picks up the suction tubing and inserts the end of the Y-catheter into the patient's mouth. She removes the Y-catheter... before she turns off the suction, coils up the tubing in her hand and replaces it in its hook (CCNK2609).*

CCNs' provision of holistic care also includes orientation and pain management of patients awaking from unconsciousness, such as in the following interaction:

*Edwin stands... at... the side of the bed as he talks to the patient; 'do you know where you are?' The patient nods... 'I'm in hospital; I came in for an operation on my foot'. Edwin nods...and asks, 'do you know which ward you're in?' The patient looks around the room and... out the room's window into the rest of the unit. He turns back and gives Edwin a blank look with a shrug of his shoulders. Edwin explains, 'your operation didn't go as planned; there was a bit of a problem with your heart'. The patient nods slowly Edwin continues, 'so you have been brought into intensive care'. Edwin pauses for a moment and then adds 'you've been here for ten days'. The patient sits silent for a moment before slowly turning to look at Edwin and asking in an anxious voice, 'have I had any visitors?' Edwin smiles, nods and replies cheerily 'yes everyday...your brother, your wife, your son', the patient smiles. Edwin smiles back and asks 'are you in pain?' The patient nods adamantly several times and replies, 'yes; but it's not really pain, just a little niggle, that's all'. Edwin asks, 'is it your toe?' The patient nods again and Edwin says, 'I'll get you something right away' (CCNE2201).*

Care is also evident here in how Edwin talks and interacts with the patient, who was not expecting to be in the ICU after their operation. In doing so, Edwin assures the patient of the situation or surroundings. Care is additionally expressed in terms of promoting patient recovery. This is captured in the statement: 'I'm making the best choices for them that I can make for their better health' (Gaynor). In this example, Gaynor constructs herself as an expert on the patient's health and this enables her to make informed choices in the delivery of care. The perception of such expertise enables CCNs a capacity for decision-making on the patient's behalf, which is necessary in the context of the ICU. This includes encouraging

patients to perform activities and accept medical interventions despite their resistance:

*She still didn't want help herself...It took me so much effort to get her out of bed...She was well enough to shower on a commode chair, but I really had to encourage her...I did it in a series of steps. I started by getting her to sit up on the edge of the bed. Then I suggested she use the commode chair at the bedside. But then she resisted... I really had to push her' (CCNB804).*

*Airlee and an unidentified CCN stand ... talking as Airlee watches her nursing student work at bed 9. The student asks the patient', would you like a neb [medication through a nebuliser]?' The patient replies 'I do think I need it; don't want anything I don't need'. Airlee calls to her student, 'she could have a neb'. The student explains she offered it. Airlee says 'she hasn't had it for four hours'. She calls the patient by her first name and tells her 'we're going to give you a neb; it'll keep you off that CPAP [Continuous Positive Airway Pressure] machine you hate so much' (CCNA703).*

These examples illustrate how encouraging and promoting patient recovery forms an integral element of CCNs' practice. What they also reveal is conflict between two cultures; the culture of nursing and that of each patient (Holland and Hogg 2001). In both cases, patients' resistance can be interpreted as arising from particular beliefs about their health and illness. The first passage signals the patient believes her illness necessitates a reduction in activity, and the second indicates the patient perceives she does not require an intervention. In both cases, the beliefs of the patients stand in opposition to those of the nurses. Furthermore, the passages demonstrate the power differentials inherent in interactions between CCNs and their patients, where application of expert knowledge by the former restricts the decision-making processes, and the agency of the

latter. This is not to say that CCNs' always exercise power to the detriment of their patients' agency, as in some instances CCNs promote patient agency through advocacy:

*Karla sits... writing up her patient's progress notes when the Registrar approaches...and asks 'did that Frusi [Furosemide] work? She [the patient] was a bit over yesterday' Karla tells him, 'I just emptied a hundred [millilitres]'. The Registrar nods and begins to walk away. Karla calls to him, 'before you go'. The Registrar... turns back. Karla tells him; 'I am concerned about you doing a trachy [tracheostomy] on a patient that is unable to provide consent' [the patient is barely conscious and is unable to communicate]. 'I think the patient should be involved in that decision making process...someone should speak with her'. The Registrar nods and says, 'we don't know if it does going to happen yet'. Karla returns his nod and says, 'well it's something you need to consider if it does'. The Registrar says 'point noted' (CCNK2614).*

Here, the CCN informs the Registrar that he is required to discuss the proposed treatment with the patient so as to meet the legal requirement of gaining informed patient consent. This indicates the CCN's knowledge of the legislative and ethical frameworks of professional nursing (detailed in the next chapter, 'The Centrality of Knowledges'), and the importance of their application within everyday practice. Moreover, the CCN's expression of concern regarding the patient's ability to consent is representative of her exercise of agency of the patient's behalf. This advocacy for the patient is an additional aspect in CCNs' multifaceted understandings of professional identity that informs their caring role (Grace 2001; Water et al. 2016).

## **Conclusion**

This chapter explored how CCNs understand their professional identities through a focus on their perceptions and performances. It revealed that participants' professional identities are underpinned by complex and multidimensional meaning-making. While there were some shared understandings of professional identity, CCNs' confusion and contradictions indicated an absence of commonly-held definitive meanings, and this mirrors the lack of clarity of the term in the literature (Johnson et al. 2012).

CCNs subjectively constructed their professional identities from within their own social contexts. As such, meanings attached to participants' professional identities are shaped and textured from within their own historical, social and cultural contexts. Professional identity is influenced by CCNs' evaluation of their nursing practice relative to other nurses, and public perceptions of the role of nurses and their practice (Hoeve, Jansen and Roodbol 2013; MacIntosh 2003). This finding resonates with conceptual propositions of the personal, interpersonal and historical socio-cultural dimensions of professional identity (Öhlén and Segesten 1998). Professional identity is informed by the professionalism of nursing, the

autonomous practice of nursing generally and of critical care more specifically, as well as qualification ranging from Certificate to postgraduate awards. Consequently, CCNs do not focus on a single aspect of their professional identities, but rather its dynamism and complexity.

CCNs' articulations of, 'how you perceive yourself' (Catrina), 'being a nurse' (Marcus), 'a part of your identity in life' (Nina) typify personal dimensions of professional identity as the experience and perception of being a nurse (Arthur 1992; Öhlén and Segesten 1998). Although this was a common perception among participants, the distinctions between being a 'Registered Nurse' (Brenda; Nina) and a 'Critical Care Nurse' (Marcus; Gaynor) reveal CCNs perceived these to be different. While not always considered as superior, being a CCN was acknowledged as being different from other nurses. These differences are explored more fully in the next chapter, Chapter Five, 'The Centrality of Knowledge' where participants engage in more elaborate processes of difference between the knowledges and practice that informs their professional identities as CCNs, and those of other nurses.

The salience of the professionalism of nursing as an aspect of participants' professional identities at the individual and collective level is evident in

the phrases 'the profession' (Catrina), 'professional life [and] how we view ourselves as professionals' (Penny). This supports the priority awarded to the transmission of an ideology of professionalism as an element of professional identity within nursing literature (Hoeve, Jansen and Roodbol 2013; Keeling and Templeman 2013). CCNs acknowledged the movement of nursing education and training to university is central to nursing's attainment of professional status. The Bachelor of Nursing is perceived as incorporating the legislative and ethical dimensions of nursing, and thus, it is fundamental to the autonomous practice informing CCNs' professional identities. Moreover, participants value the Bachelor of Nursing for the transmission of particular forms of knowledge and an ideology of professionalism, and thus, it represents a boundary of difference and similarity across which CCNs construct their professional identities. This construction of difference in knowledges across and between jurisdictional boundaries is further detailed in the following chapter, 'The Centrality of Knowledges'.

CCN's ability to 'tweak' (Nina; Gaynor), 'initiate' (Gaynor) and control interventions support theoretical propositions and correspond to empirical findings of the significant contribution of autonomy to nurses professional identities, particularly within the specialty of critical care nursing (Flynn and Sinclair 2005; Iliopoulou and While 2010). What is



notable is that CCN's autonomy is not confined to the jurisdiction of nursing. Rather, autonomous practice is negotiated as dynamic jurisdictional boundaries are demarcated and blurred by CCNs and medical practitioners in the fluid environment of contemporary health services (Allen 2000; Carmel 2006a; Lane 2006; Nancarrow and Borthwick 2005).

CCNs additionally constructed their professional identities around characteristics and behaviours they associated with being a nurse and professional. They saw their 'mannerisms...how you carry yourself...[and] etiquette' (Catrina), the extension of 'respect' (Nina), and being 'neutral' (Brenda), as integral to being professionals. These behaviours represent normative expectations of professions within functionalist understandings (Parsons 1939; 1968), and are distinguished for interactionist theorisations of professional identity as the performance of a subjectively understood social role (Goffman 1959; Hughes 1971).

The implications of participants' subjective understandings of their professional identities are they contrast the objective theorisation of the professionalism of nursing. This divergence on what constitutes professional identity points to a weakness in CCNs' shared group

ideology, and this reflects a possible lack of strength in group solidarity that, theoretically, characterises professional groups (Abbott 1988; Freidson 1970b; Hughes 1971). Therefore, the confusion and contradiction of participants' professional identities has the potential to complicate constructions, and this has negative implications for worker satisfaction levels and retention rates within the ICU.

The multidimensional features of CCNs' professional identities are presented further in the following chapter, where they are considered through analysis of CCN practice within a framework of nursing knowledges. While this chapter highlighted the differences in CCNs' perceptions of their professional identities, the next chapter demonstrates that while participants hold disparate perceptions on what being a nurse and professional means, they are bound together as a group by a shared knowledge base that provides meaning to their actions, language, rituals and utilisation of artefacts within everyday practice.

## CHAPTER FIVE

# The Centrality of Knowledges

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### **Introduction**

The chapter argues that, despite different constructions of professional identities, CCNs are bound together as members of a culture-sharing group by their distinct nursing knowledges. Nursing knowledges encompass five aspects that guide CCNs' practice, and these are central to professional identity as they provide meaning to the actions, rituals, and utilisation of artefacts that inform its construction within their everyday practice. I draw on examples of CCNs' knowledges and how they qualify their understandings and mastery of the skill-based tasks of their practice. In addition, the analysis presented in this chapter demonstrates how nursing knowledges underpin processes of inclusion and exclusion that inform CCNs' professional identities. The analysis found that CCNs attach value to distinctive forms of knowledges, which are perceived to be unique to the practice of nursing generally and to CCN practice more specifically.

CCNs' knowledges are significant as they are employed to demarcate professional boundaries between themselves, nurses outside the ICU, and other health professionals. Participants actively attach individual meanings and values to their knowledges to construct difference between themselves as individual practitioners, the nursing profession more broadly, and other health professionals. This not only informs their professional identities through excluding specific groups of professions and nurses as 'others', but simultaneously includes, unites and strengthens CCNs' sense of social identity based on shared notions of similarity of practices and knowledges.

To understand how CCNs structure nursing knowledges to inform their professional identities, I will examine how this through exploring five aspects:

- Theoretical knowledge;
- Clinical knowledge;
- Technical knowledge;
- Tacit or experiential knowledge; and
- Legislative, ethical and procedural knowledge

The categorisation of these knowledges arose from my own analysis of CCNs' application of knowledges to the multifaceted aspects of their practice. While initially inductive, the themes were developed from theoretical and empirically evidenced knowledges within nursing and sociological literature.

### **Theoretical knowledge**

Participants' practice involved employment and transmission of what I define as theoretical knowledge. Theoretical knowledge encompasses two aspects. The first element is the biomedical knowledge that is most often associated with medicine, and this encompasses pure scientific knowledge from anatomy, physiology and pharmacology. The second element is evidence-based nursing theory, which refers to systematically developed empirical evidence that underpins the provision of holistic care. While the first aspect of these knowledges overlaps with the science of medicine, the second is a distinct theoretical knowledge base focusing on care, rather than cure (Nightingale 1969). Theoretical knowledge is fundamental to CCNs' understanding of underlying physiological, psychological and social reasoning behind nursing and medical decision-making, as well as performance of clinical interventions and possible consequences.

CCNs contrasted theoretical knowledge against the knowledge transmitted during traditional hospital-based training. This was most evident when CCNs in the most experienced group alluded to differences in knowledges between the two systems of nursing training and practice; vocational and professional, as explored in the previous chapter:

*There was this big contrast of being professional career nurse to we are doing this as a vocation. And the actual clash in the training itself, you know, there's many ways to do a bedpan or fold a bed versus where I see the academic ability of some of the girls [sic] coming out [from university] much more advanced than what I did (Gaynor).*

Gaynor distinguishes the two forms of knowledges that inform each approach to nursing practice (Keleher 2014). On the one hand, there is the instrumental knowledge necessary for proficient task completion. This type of knowledge was the focus of 'on the job' within hospital-based training. On the other is the systematic evidenced-based theoretical knowledge taught in university nursing courses, which underpins the autonomous practice of holistic patient centred care (Keleher 2014). This distinction was made only by hospital-trained participants within the most experienced group. This is demonstrated in the below field note excerpt, which describes a conversation between CCNs during a lull in

activity on a late shift (the underlining represents the participant's emphasis):

*'We were hardly taught anything!' exclaims Donna. The two CCNs nod. Donna shakes her head, 'we were told that the open end of pillow slips had to face away from the windows. But no-one explained why'. She looks to the other CCNs and asks, 'do you know why?' One laughs and waves her hand dismissively, 'oh that comes from the days Florence nursed in the army tents and it was about keeping the dust from blowing in and settling in the linen'. The other CCN laughs, 'in the hospital where I trained the open pillowslips had to face away from the window because it looked neater'. Donna laughs and explains, 'all I was told was that if they faced the other way the patient could die. I am so glad we are so much more educated about why we do the things we do now; we have that higher understanding' (CCND1008a).*

Thus, the hospital-trained CCNs contrast the instrumental nature of nursing knowledge transmitted to them during their in-hospital apprentice style training with the depth of theoretical knowledge transmitted through university-based nursing education. The examples disclose how CCNs attach differential value to each form of knowledge to distinguish and establish their tertiary-based theoretical knowledge as central to their professional identities.

The hierarchy of CCN knowledge is evident on occasions when tertiary-educated CCNs bring into question the lack of theoretical knowledge of hospital-trained CCNs. An example of one such occasion is seen in the following extract from field notes taken while observing moderately

experienced Karla one night shift, after an older hospital-trained CCN had nursed the same patient for the previous two shifts:

*As Karla works with the patient's CVP line she makes a loud whistling sound and says flatly, 'huh wrong lumen' as she shakes her head. She speaks aloud, 'someone has attached the wrong lumen to the monitor' as she shakes her head and sighs, 'that just shows that they don't actually know what they are doing' (CCNK1903).*

This passage shows how CCNs draw on differences in theoretical knowledge bases of hospital and university-trained nurses to construct their professional identities. It points to a perception of limitation in the theoretical knowledge base of the CCN who had been allocated to the bedspace on the previous two shifts. In doing so, it constructs a hierarchy between CCNs' knowledge bases as well as their resultant practices. The questioning of the CCN's ability to be an effective nurse acts to promote Karla's own capabilities, and thus, her superiority in this area on this occasion (Jenkins 2014). In contrast to moderately experienced university-trained CCNs, the more experienced university-trained CCNs in this study seemed to disregard the differences between themselves and the hospital-trained CCNs. Instead, they focused on the recognition of similarities as this next example shows:

*Ultimately I can see she [unidentified CCN] has a very strong knowledge base... if she's ever come up there [to the Observation Area] and she's tried to problem solve, she's gone through every step that I would expect before she comes to me' (Indiana).*



Here, Indiana identifies similarities between CCNs with different training and education. In stating that one CCN has 'a very strong knowledge base' and her 'problem-solving' involves '... every step that I would expect', Indiana signifies theoretical knowledge is valued and shared by CCNs' construction of professional identities, whatever their qualification.

However, as previous participants have suggested, this form of knowledge is employed in a manner that both unites and separates CCNs through inclusionary and exclusionary processes. While these processes of difference are applicable to all forms of knowledges that constitute nursing knowledges, this application is most pronounced with theoretical and the clinical form of knowledges.

### **Clinical knowledge**

I define clinical knowledge as that associated with CCNs' practical application of theoretical knowledge, and its possession is regarded as integral to performance of clinical activities. In discussing what they believe to be the central clinical activities informing their professional identities as CCNs, participants most often identified the task of patient assessment. When doing so, they additionally emphasised that such clinical skills are informed by the biomedical and evidenced-based aspect of their knowledge bases. As Indiana explains: 'A lot of what we do is just

observing, observing...partly observing and partly knowing subtle little pointers that actually are important.'

The activity of observations, or 'obs' as the participants refer to it, is routinely undertaken on an hourly basis and more frequently if patients are receiving specific medications. The passage below from fieldnotes describes the activity of observations:

*Airlee drains the urine from the patient's catheter bag in a jug, measures it and records it in the fluid balance section of the ICU chart... She then takes a syringe and collects an arterial blood sample which she sends her nursing student to analyse ... She collects a thermometer, takes her patient's temperature and records it; she finally records the patient's blood pressure, heart rhythm, pulse rate and oxygen saturation rate from the figures displayed on the monitor (CCNA 702).*

In the following observation excerpt, Catrina has her nursing student identify the measurements that she is required to collect when undertaking hourly observations:

*Catrina asks, 'what obs are you talking about?' The student counts off on her fingers, 'pulse, temperature and blood pressure, measure her urine output for the hour, blood gasses'... Catrina nods (CCNC405).*

The clinical knowledge that underpins the task of patient assessment was observed as fundamental to informants' professional identities as CCNs. Moreover, such knowledge was perceived by participants as particular to

the practice of critical care nursing, rather than nursing more generally. This is what is conveyed when clinical knowledge is described by CCNs as a primary aspect in the performance of tasks that are routine within the ICU, but not necessarily on other hospital wards:

*You need to be able to incorporate... to be able to think about a lot of [body] systems at once...you can't be just focussing on the one thing... We [CCNs] know more in-depth. And I think we should know more; we're fiddling with things more than they do on the wards, we're more invasive, we change a lot of things, we control a lot of systems, so we should know more (Nina).*

Nina highlights the way that she perceives of differences between her clinical knowledge as a CCN, when compared to that of nurses working on hospital wards outside the ICU. Note the narration of extension, evident in the lexicon 'a lot', 'more in-depth' and 'a lot more than they do', that constructs CCN practice, and the clinical knowledge that underpins it, as broader and deeper when compared to that of nurses outside the ICU. Further, while Nina began relating in the first person, this was quickly changed to the collective plural 'we' to construct her identity as a professional both individually and as part of a collective. This movement between personal and collective pronouns was common among participants as they switched between them across different aspects of their practice. For example, my observations show that CCNs employed a

collective pronoun, 'we' when interacting with a patient's family, however, they chose to use personal pronouns, 'my' and 'I' when requesting assistance from a Medical Officer:

*Airlee speaks into the intercom to the patient's family, 'she's only just got here; we're just making her comfortable and giving her some more pain relief' (CCNA103).*

*Airlee approaches the Medical Officer and smiles. He returns her smile as he asks 'what do you need?' Airlee replies, 'It's nothing serious. My patient has got nausea and I need someone to write up some antiemetic' (CCNA105).*

The choice of different pronouns to refer to themselves when interacting with different social actors is interesting as it suggests their presentations of professional identity are underpinned by the achievement of particular aims (Goffman 1959). Airlee's choice of 'we' in conversation with her patient's family members has a similar effect to Nina's earlier quote, as it indicates a collective professional identity. This includes inclusion between herself and the other CCNs as they work together to achieve the same aim of optimal patient care. In contrast, Airlee's exchange with the doctor includes the personal pronouns 'I' and 'my'. These act to promote her autonomy in the care of her patient through exclusion of other CCNs. This shift of language signifies that professional identities are constructed at both the individual and collective level. Each construction is performed to different social audiences and these are underpinned by both different perceptions of professional identity that are informed by particular aims.

For example, professional identities are constructed at the individual level in order to showcase the significance of clinical knowledge to CCNs' autonomous practice within the ICU:

*It comes back to that [clinical] knowledge; you've gotta know what the next step is to fill in that blank, or to maintain something or keep your patient going until your doctors get back there to review them (Catrina).*

The lexicon of 'you' and 'your' indicates Catrina's perception of autonomous decision making in her practice. Yet, on closer inspection, her words 'know the next step' and 'fill in that blank' align with knowledge of a formally regulated set of actions. This signifies that clinical knowledge is underpinned by established rules, routines and procedures, or what Jamous and Peloille (1970) term 'technicality'. While technicality makes a sizeable contribution to CCNs' practice, participants frequently exercised autonomy to override established protocols and prescribed treatment orders. This was the case with Fern, who exemplified the management of a situation when alluding to the autonomous decision-making of the CCN night staff.

*The anaesthetist looks from Fern to the PCA [Patient Controlled Analgesia machine] and asks, 'can you just have a look and tell me how much is left in her PCA?' Fern does so and answers, 'there's still about thirty mLs left'. The anaesthetist nods and then quickly frowns and asks, 'why is there so much left?' Fern explains, 'that was because we had to suspend it for a while overnight as she was a bit too sleepy'. The anaesthetist nods (CCNF2411).*

These excerpts from Catrina and Fern indicate that clinical knowledge informs their professional identities in the management and negotiation of technicality. That is, CCNs are required to make decisions and execute clinical activities in the absence of a medical practitioner, relying on either experiential or procedural knowledge (discussed later in this chapter), thus reflecting the high degree of autonomy within CCN practice (Flynn and Sinclair 2005; Iliopoulou and While 2010; Varjus, Suominen and Leino-Kilpi 2003).

While these extracts indicate a solid clinical knowledge-base that enables CCNs' autonomous clinical decision-making, they also suggest a taken-for-granted assumption of the dominance of the medical profession. Catrina's reference to managing the patient 'until your doctors get back to review them' infers an ultimate reliance on the decisions of medical professionals within her practice. The authoritative clinical decision making of doctors over the CCNs is further demonstrated when the anaesthetist, who had provided the drug order, instructs Fern to establish whether his directive had been followed, and to justify her actions when these were not met. This means the autonomy CCNs exercise by virtue of their clinical knowledge has limits that are externally imposed by the medical

profession, and it is within these that they willingly operate. At times however, the medical profession expanded its jurisdiction into domains that nurses might see as theirs: For example, Karla noted:

*The Interns often do tasks that were traditionally our tasks. So often you go to do a patient assessment, do the obs and you'd find...it's already been done by an Intern. Or they [Interns] would put cannulas in and take bloods and those sorts of things which was generally our role; it was always a nursing responsibility (Karla).*

The extracts of Catrina, Fern and Karla suggest that the boundaries between medicine and nursing, particularly in acute nursing areas, are becoming increasingly blurred. As CCNs autonomously engage in clinical activities that are within the jurisdiction of medicine, medical professionals do likewise (Nancarrow and Borthwick 2005; Tye and Ross 2000). Such negotiations of practice jurisdictions on the basis of practicality rather than clinical knowledge, extended to CCNs' assimilation of low skill activities of auxiliary workers into their practice. Gaynor explained how some shifts, 'are cruisey; there's the basic stuff to do...you might end up taking out the rubbish'. My fieldnotes reveal that CCNs often engaged in the assimilation of activities of house services staff:

*Karla coils the ECG (Electrocardiograph) leads around her hand as she threads them through a detergent wipe. She looks skyward and sighs, 'it's very quiet...I'm so bored.' She nods to the leads in her hand, 'The ward aides usually do this but I've got nothing to do' (CCNK1302).*

*Donna asks her patient 'do you want anything to drink?' He replies 'yes' and gives his order 'white tea with two sugars'. She nods to him, 'I'll be back shortly' and heads to the kitchen (CCND1003).*

While the majority of participants happily engaged in the low skill work activities of house services, it was also a source of tension between CCNs within the unit. The difference in CCNs' attitudes is illustrated by Karla:

*We don't have hospital aides after hours. There's an old school of thought that nurses don't do any of the hospital aide work; so no emptying linen skips, cleaning of the pan room, none of that overnight... So some of the older grade fours have been going round telling all the younger nursing staff, 'no you don't need to do that', 'hospital aides will do it in the morning', 'just leave it, it's not our job'; you don't, it's not your job, you don't do it'. Whereas if the linen skips are overflowing and the pan room is clogged up, of course I'm gonna clean it. I'm not gonna leave it for the person who comes on at 7 o'clock in the morning to go, 'oh my God the place looks like shit' (Karla).*

The divergence between acceptance and rejection of workplace assimilation that Karla described sheds some light on how CCNs perceive their role in the workplace, and the lack of value they attach to low skills activities of their subordinates. Some CCNs clearly demarcated between their own jurisdictions and those of lower ranked workers. This offers an understanding of the value CCNs attach to their clinical knowledge as they perceived its possession positions them in a knowledge and work hierarchy that qualified them as above the task of less prestigious others outside nursing. Significantly however, a lack of workplace tasks could motivate CCNs to re-assimilate low skill activities, including taking out



the rubbish (Gaynor), cleaning (Karla) and making drinks for their patients (Donna) into their practice.

CCNs' clinical knowledge is shared within the ritual of nursing handover.

The significance of clinical knowledge in offering a more complete picture of the patient during handover is illustrated in this next interview excerpt:

*We do handover...we share things...how the patient is, what's the patient's history, how to look after them. If I take a patient...[from a location outside the hospital] I get a handover from them...sometimes from the doctor, or sometimes from the staff from the hospital itself give us a call and tell us. So maybe an intubated patient with some... problems, alright, that's all we know. You do an assessment and we get information from others. Or when I handover, if I have only 10 per cent information I make it twenty and handover, and the next nurse will make it twenty five (Marcus).*

In this extract, handover is described as an often repeated transmission of clinical information on the patient between CCNs and other staff members.

Although there is no explicit reference made to clinical knowledge, there is an exchange of information including the patient's condition, history and 'how to look after them' as well as generating further information through an 'assessment' (Marcus). The following field notes demonstrate how clinical knowledge is integral to handover in its various forms. This includes full ward handover and bedside handover which occur at CCNs change of shift:

*At 7 am the chatter subsides and the CCNs look to the clock on the wall and shift in their seats. The night shift CCNIC hurries in and apologises for being 'a minute late' and asks, 'is everyone here?' as she looks around the room... 'Right; I'll start' She provides medical, psychological and social details of each patient in the unit by bed number at a rapid pace drawing on biomedical discourse, in 'Bed 1 is (patient's name); he's a 56 year old male who is here for BiPAP. He has a history of IHD and IDDM'. The CCNs all begin taking notes on each patient and their care overnight. (MJB2401).*

*Fern stands at the head of the overbed table, looks over at the two CCNs and nods, 'I'll give handover now'. The CCNs look down to the sheets of paper in front of them as Fern states the patient's name, age and diagnosis of 'community acquired pneumonia'. She launches into clinical jargon to provide the patient's history. The two CCNs scribble on the sheets of paper and nod. Fern discusses the medical treatment and nursing tasks that have been performed since 7am and reports on the patient's observations, the medication delivered and important decisions made by the patient's family regarding treatment using the terms 'CPAP' and 'BP' as she points to the relevant sections of the patient's ICU chart, 'as you can see here, it's been 40 and above'. The CCNs make notes and nod (CCNF1404).*

These field notes reveal that CCNs posed no questions during the information transfer of handover. Rather, they nodded and busied themselves taking notes, which demonstrate engagement with, and understandings of, the information provided. The CCNs' nodding and lack of queries are indicative of shared knowledge that informs their understandings of terms such as 'BiPAP', 'IHD' "IDDIM' and 'CPAP'. The meanings attached to particular terminology are not only shared between CCNs, but also between CCNs and members of medical staff:

*Hallam continues, 'he's [the patient] febrile; 38.9'. The MO asks 'have any blood cultures been done?' Hallam checks the patient's notes, '24-36 hours ago'. The MO instructs Hallam 'take cultures again...a peripheral and CV line sample' and begins to walk away. Hallam calls him back, 'he's also dehydrated; negative a litre'. The MO turns back quickly, 'a litre?' Hallam*

*nods. The MO confers with the Registrar and tells Hallam, 'we'll give him some vancomycin'(CCNH1901b) .*

Such interactions shine light on the importance of CCNs' clinical knowledge in shared meaning-making of actions, language, rituals, and employment of artefacts that contributes to their professional identities. It also uncovers co-construction of knowledge with medical professionals, as seen in Hallam's interaction with the MO, who, in turn consults the Registrar. This supports a shared language that creates a shared identity within the ICU, while preserving a hierarchy of knowledge.

While clinical knowledge is a significant informer of CCNs' professional identities, particularly when it is synthesised with theoretical knowledge, these two forms of knowledge are not sufficient to effectively perform the CCN practice role that informs their professional identities. Technological changes, and the technological imperative within the dominant biomedical approach to health have seen the incorporation of more increasingly advanced technology into nursing practice, particularly in the ICU (Almerud et al. 2008a; Almerud et al. 2008b; Barnard and Sandelowski 2001; Turner 1987). This means that CCNs have a close working relationship with technology, and thus, they regard technical knowledge as a significant aspect of their professional identities.

## **Technical knowledge**

Technical knowledge is the knowledge that underpins and guides

participants' engagement with common artefacts that are specific to the

ICU environment. It includes knowledge of the preparation, application,

management, and regular maintenance of routinely utilised technology,

and is connected to what Little (2000) terms 'technological competence'.

This form of knowledge advises CCNs' troubleshooting of both patients

and technology. Although technical knowledge focuses on the hands-on

"how-tos" of CCNs' clinical practice as opposed to the whys, it is not

perceived to be valuable by CCNs in and of its own. Its value lies in the

way it accompanies the theoretical and clinical knowledge that underpin a

specific technology's application.

Technical knowledge is transmitted to nurses as students during

simulated practice learning sessions and practicums, as well as being

continually developed throughout their nursing career. It is furthered as

staff attend training courses to become educated on newly introduced

technology as it became available for application. This is the case with

Brenda who, following her interview was leaving for Melbourne to attend

a three day course on ECMO (Extracorporeal Membrane Oxygenation).

Technical knowledge was acknowledged when informants identified the technology necessary to fulfil the CCN role and its particular goal of care provision to critically ill patients. The salience of technical knowledge to CCNs' practice can be seen in the following examples in which participants discussed the technology that is both fundamental to their practice and exclusive to the ICU. The ventilator, used to maintain respiratory function in semi-conscious and unconscious patients as well as patients experiencing severe respiratory complaints was seen as particularly fundamental:

*The ventilator... because people come to us if they can't breathe...dialysis would probably come second. Yeah. And you've got monitors there, there's always constant monitoring' (Nina).*

*The ventilator... because ventilation isn't done, especially for long term, anywhere else in the hospital... then the other one that we probably do that nowhere else in the hospital does at all would be um intra-aortic balloon pumping... We also do ECMO now as well; we've just started doing that recently and that is a massive critical care specialty (Karla).*

Mastery of technical knowledge was vitally important for CCNs' professional competence as technology is integral to the performance of the majority of nursing tasks within the ICU, particularly patient monitoring and assessment. As a result, an understanding and use of technology are crucial to CCNs' professional identities. The next passage

demonstrates CCNs' reliance on technology to undertake routine hourly patient observations:

*Donna takes her patient's hourly observations. She takes his temperature with an electronic thermometer... She sits at the overbed table and looks to the figures displayed on the monitor as she records the patient's heart rate, rhythm and blood pressure the designated sections of the chart. She then looks at the ventilator screen and records a series of displayed numbers in the respiratory section of the ICU chart. She moves to the end of the bed on checks the hourly urine... and records the measurement in the output section of the fluid balance section of the chart before using a calculator to add this measurement to the fluid balance total and recording it in red ink (CCND3011).*

Technical knowledge was indispensable to participants' operation and application of health technologies, and in recognising and managing issues associated with its use. This included identification and management of technological faults such as the blood pressure feature of the monitor, as in the following example:

*Nina applies a blood pressure cuff to the patient's upper left arm and presses a button on the monitor. The alarm on the monitor rings out. Nina looks quickly at the flashing figures the monitor and makes a distasteful sound under her breath as she turns and heads towards the door and calls to the patient, 'It's okay; I don't think the machine is working properly'. Nina calls to another CCN, 'how's this man's blood pressure been today?' The CCN replies nervously, 'up a bit, why?' Nina explains, 'it's a bit high now, but I think it may be the machine; has his diastolic been over 200?' The CCN says, 'oh no', and shakes her head. Nina returns to the patient and smiles and nods as she reassures him, 'it's not you; it's the machine. I'll take it manually' (CCNN3401).*

Here, Nina readily recognised a technical issue through her active questioning, rather than uncritical acceptance, of the monitor's result. While she drew on her technical knowledge to interpret the monitor

as indicating her patient's blood pressure is 'a bit high now', she suspects the objective measure is the result of a faulty machine. In order to overcome her doubt, Nina conferred with another CCN to assess if the recording on the monitor was correct. The information that her patient's diastolic blood pressure had been below the level of 200 millimetres of mercury provides Nina with a reason to accept her suspicions of the monitor's incorrect measurement. To overcome the limitations presented she performed a manual, rather than electronic, recording of her patient's blood pressure. Her technological knowledge therefore facilitates her ability to identify and correct technological failings.

CCNs also recognised and managed technical issues in situations where they had minimal notification of a problem from technological sources. On these occasions, informants detected issues through observing changes in machinery's regular operation that were not necessarily indicated by its alarm systems:

*Gaynor tells me 'I think there's a leak in the circuit'; she points and nods to the ventilator. 'I thought I heard a sucking noise while we were turning him [the patient]'. She tilts her head to one side and pulls a face as she explains, 'I'm not really sure if it's water or air getting in...when there's a leak, it makes a farting sound; this sound was more of a blowing, but not, a farting sound'. She shakes her head... 'I don't know; the alarm barely sounded'... She sniffs and tells me, 'it was probably because he was breathing a little bit*

*and the machine was overcompensating for it'. She shakes her head. (CCNG3106).*

Nina and Gaynor's experiences and management of minor technological issues stand in contrast to those that threaten to compromise the patient's life. This was the case with Brenda and Edwin's application of technical knowledge in response to a nursing student who called out in a panic as the ventilator of the patient she was nursing temporarily malfunctioned:

*Edwin hurries to the nursing student who looks at the alarming ventilator with a flushed face and furrowed brow. The student quickly explains, 'the ventilator switched itself to BiPAP [Bi-level Positive Airway Pressure] and I can't get it back to CPAP [Continuous Positive Airway Pressure]'. Edwin silences the alarm. He looks closely at the face of the machine and then to the bags of fluid hanging from a pole around the patient's head and begins to untangle them. Brenda comes over and asks 'what's happening?' The student explains, 'the machine just switched modes'. Brenda nods, 'yeah that happens sometimes'. Edwin looks to Brenda and says in a trivial manner, 'it could be the new software'. Brenda replies, 'just wait and see what happens now; when it does this it normally flicks itself back to CPAP' (CCNE1106).*

In these excerpts, Gaynor, Edwin and Brenda's management of a temporary dysfunction of technology demonstrates their technological competence within everyday practice (Little 2000; Wikström and Sätterlund Larsson 2004). Moreover, the exchange between Edwin and Brenda conveys how the transmission of technical knowledge is a means of developing technological competence in line with the ideology of professional development within nursing (Little 1999; Little 2000). In this



case, the CCNs' attribution of blame in failure is specifically technological, rather than related to nurse actions, and thus their explanations serve to inform the student's technical knowledge in relation to this specific technology. While the CCNs perceived technical knowledge as significant in informing their professional identities, they emphasised the need to supplement it with clinical and theoretical knowledges to overcome the indeterminacies that technology can present. The passage below illustrates the importance of technical, clinical and theoretical knowledges to the application of technology within the ICU. It also conveys that technological competence is salient in constructing professional identities as critical care nurses:

*Understanding the technology that we have is really important. I think it's a huge part of our job...understanding the ventilators and... the physiological aspects of it as well ... like ...the dialysis machine...(the) balloon pump if we ever have it...ECMO, yeah all that stuff we do. You need to understand the machine and also what you're doing to the patient (Penny).*

In this passage, Penny emphasises the importance of understanding the technology and its applications within her practice. The reiteration of the word 'understand' suggests that knowing how technology works as well as how to utilise it correctly and effectively forms an integral aspect of CCNs' technical knowledge. While Penny does not explicitly identify technical knowledge as unique to CCNs, the use of inclusive pronouns

suggests boundaries are drawn over the ownership of technical knowledge (Liberati, Gorli and Scaratti 2016). This ownership is supported by other participants when I asked if they felt their professional identities were threatened by other health professionals inside the unit. They explained their knowledge base, particularly the technical aspects, is distinct to that of other health professionals. Karla stated:

*There are very distinct things that we do that nobody else knows how to do. Doctors, they have no idea how to set up a dialysis machine or how to work it. All they know how to do is tell us what fluid they would like (Karla).*

In this quote, Karla constructs her professional identity through describing perceived differences of knowledges between CCNs and medical officers. She draws on a narrative of limitation to demarcate the two groups as the superior in-group of CCNs to which she belongs, and the inferior out-group of doctors to which she does not (Allen 2001; Dingwall 2008; Turner 1986). This extends the boundaries that Nina earlier drew between herself and ward nurses with regards to clinical knowledge (see pages 140-41). CCNs' employment of technical knowledge spreads to marginalising MOs from the ability to use, and interfere with, routinely utilised machinery. An example is the machine to analyse arterial blood gas (ABG) samples as Donna explained while she performed an analysis:

*Donna pushes the buttons on the machine and inserts the syringe as she tells me, 'we don't let the doctors have the code; it stops them using the*

*machine. They don't really know how to use it and they end up pressing every button they can try; they muck up the machine's calibration and we have to call someone in to fix it; it could take two days and then we don't have a back-up' (CCND3012).*

This process of exclusion of the doctors from the technical knowledge associated with the performance of specific work activities, (in this case the analysis of ABGs), is characteristic of rhetorical boundary work. Like Karla, Donna's lexical style demonstrates the inclusionary and exclusionary language of 'us' and 'them' as she alludes to relational differences between CCNs and doctors. This relates to the limitations of knowledges. Moreover, the practical strategy of withholding significant information necessary to operate the machinery serves to limit doctors' encroachment into an area of activity the CCNs perceive as their own. In not disclosing the code for the ABG machine to the doctors, the CCNs create a form of nursing dominance as opposed to medical dominance, and exert a small amount of control in an environment where they possess little authority (this is further detailed in the next chapter, 'CCNs' Knowledges and Inter-Professional Interactions'). Furthermore, this nursing dominance minimises disruption to their own routine through the withholding of operational codes.

While participants accounted a high reliance on technology, they also drew attention to the prioritisation of complementing this with the provision of holistic care. CCNs from the more experienced and moderately experienced group expressed how they perceive basic patient care, rather than technological intervention, as central to their practice:

*One of the biggest things of good quality nursing care is that's your basic nursing care; curative measures. You can tweak them [patients] up, you can poke them with this, you can poke them with that, but if you're not treating the patient, if you're not doing basic nursing care that shapes my whole role, you're lost before you start (Gaynor).*

*You need to understand the importance of hygiene care, mouth care, eye care, all of that. And a number of those nurses aren't doing things like mouth care, eye care 'cause they don't seem to understand the importance of it (Karla).*

The importance of synthesising technology and holism was evident in observations in which CCNs acted as mediators between technology and the patient. This is the case in the following examples:

*Catrina picks up the PCA [Patient Controlled Analgesia] control and gently calls the patient's name softly... She asks, 'do you remember the little machine we gave you so you can look after your pain?' The patient responds, 'huh?' Catrina takes the patient's hand and speaks in a hushed tone; 'I've got this machine for you so you can look after your pain'. She places the PCA control in the patient's hand and asks, 'can you feel that?' The patient replies 'ah-ha'. Catrina continues 'Good. Now when you feel some pain you push this big yellow button'. The patient opens her eyes and sits up to look at the PCA in her hand and nods. Catrina goes on 'Good. Now you need to remember to push it when you need to. Can you push it for me now?' The patient pushes the button. Catrina encourages her 'Now you need to keep that up. Ok?' The patient complains, 'If I use it too much I get sleepy. I'll sleep all day like I did yesterday.' Catrina scoffs, 'Sleeping all day is better than being uncomfortable. The more comfortable you feel, the quicker you'll*

*heal and the quicker you can get away from all of this', as she gestures to the variety of machines, monitors and IV hanging on poles around the bed (CCNC0505).*

*The patient sees the oxygen mask in Donna's hand. He speaks in a weak voice, 'can you put it back on please?' Donna glances at the monitor before she says, 'you don't really need it on; and I think you should avoid having things you don't really need at the moment'. The patient looks at her and insists, 'but it won't hurt me will it?' Donna sighs and answers, 'no, it won't hurt... okay then' and reaches over to apply the thick plastic mask over the patient's nose and mouth and uses both hands to apply the straps to his forehead and chin. She tells the patient, 'I'll get something soft to put in against those straps'. She fetches some gauze squares, folds them lengthwise and inserts them between the straps and the patient's skin as she talks gently to him, 'is that better?' (CCND3009).*

In the first example, Catrina acts as a mediatory between technology and the patient by explaining the Patient Controlled Analgesia (PCA) machine with the aim of supporting her patient's self-management of pain. Donna, in the second passage, takes a mediatory role as she assures her patient that he does not require the technological intervention he requests. When he insists, and she notes that it will not cause him harm, she replaces the mask and takes further steps to minimise its discomfort to the patient. In both cases, the CCNs act as a link between the patient and the technology in a manner that represents the provision of holistic care. Technology therefore, is a tool that assists in patient care that must be augmented with the CCNs, rather than determining patient care in its own right (Almerud et al. 2008b; Barnard and Sandelowski 2001).

CCNs' mediation of technology also extended beyond the patient to include the patient's significant others. This is the case in the following example:

*The male relative points to the ventilator and the thick tubes lying across it, 'what does that do for him?' Donna explains 'that's what we call BiPAP; it's helping him to breathe a bit better. It works by forcing air into his lungs'. She sees confused looks on their faces and continues, 'the best way to describe what it does is if you think about winding down the car window and sticking your head out while you doing 100ks an hour'. She indicates with a turning motion and then the action of holding the window and sticking her head out and then it being caught by the wind with her mouth wide open and head back. She looks at the relatives, 'you know the air just gets forced in', and they nod (CCND3008).*

Here the CCN mediates between the technology, the patient, and patients' family members in a manner congruent to the activity of caring within the context of intensive care units (Holden, Harrison and Johnson 2002; Wilkin and Slevin 2004). While the aim is care provision, such practice-based attitudes extend to the relationship between technology and others, such as medical professionals, on occasions when delivery of care is not the central focus. The following passage illustrates how CCNs mediate between technology and other health professionals, who are excluded from its use, and also demonstrates their technical competence:

*The Intern looks at the ventilator screen and points to it as he asks Donna, 'why the border is orange?' Donna cranes her neck to see the screen across the other side of the bed and then looks with a raised eyebrow to the Intern 'that's because it's non-invasive'. He looks at the patient for a moment and asks, 'that's because it's BiPAP yeah?' Donna replies, 'yes'. The Intern looks back at the ventilator and asks, 'do you have to set it to do that, or is it automatic?' Donna explains, 'it's automatic; it comes on*

*that way when we turn it on'. The Intern nods 'I've never noticed that before' (CCND3010).*

CCNs additionally mediated between technology and other CCNs when they provided instructions on correct application and maintenance. This can be seen in the next example with Donna, the Float and the CCN In-Charge (CCNIC):

*The CCNIC tells Donna 'the machine needs zeroing'. The Float moves to flatten the patient's bed to 180 degrees as Donna explains to the patient 'we're just lying you flat (first name)'. When the bed is flat Donna looks to the monitor. She looks back at the Float 'do I lock it first?' He shrugs his shoulders. The CCNIC comes over... 'lock it first'. Donna turns a small plastic lever... The CCNIC continues 'push the pin wheel, deflate, make sure the trace comes back, unlock it, good' (CCND2902).*

In contrast to the female informants, male CCNs tend not to play a mediatory role between the technology and patients' relatives. This was evidenced as Marcus' patient's son visited the unit early one morning after his father has been transferred to the unit overnight.

*The patient's son arrives and stands at the doorway and looks wide-eyed at his unconscious father lying in bed being ventilated. Marcus continues to adjust monitors and IV bags around the patient. The patient's son, ashen-faced and trembling still stands at the doorway. Marcus eventually turns to the son, and asks flatly, 'was he [patient] tubed when you last saw him?' The son's lip trembles as he answers, 'Ummm'. Marcus continues, 'yes well he's tubed now', and turns back to the monitors (CCNM3701).*

This interaction indicates that Marcus' focus on the operation of technology, rather than a holistic approach, informs his professional

identity. This was witnessed in his interview when Marcus further elaborated:

*I think... as a critical care nurse [we] look to the monitor [more] than to the patient some, most, some of the days. The monitor tells us everything... what the heart is like, what the ECG is like, what the blood pressure is like, O2 saturation; everything (Marcus).*

The utilisation of the phrases ‘most, some of the days’ and ‘the monitor tells us everything’ indicates a perception of technology, rather than the patient as the focus of practice. This focus on technology prioritises the objective, over subjective elements of critical care nursing (Almerud et al. 2008b). Support for this interpretation is offered by female participants such as Brenda who said:

*Often people come to ICU because they like the more machinery component; that is certainly shown. Especially with men, they seem to thrive on electronics or something that goes ‘ping’ (Brenda).*

The departure of all but one male participant from the unit before the final interview phase of the study limited follow-up of my observations, however, that one resigned from the unit to undertake acute medical training in emergency services does offer implicit support of male CCNs’ prioritisation of technology. Despite the salience of technology to CCN practice and professional identities, more experienced female participants



indicated they did not place total uncritical reliance on technology, but rather viewed it as supplementing their tacit knowledge.

### **Tacit knowledge**

CCNs synthesised their clinical, technical and theoretical knowledges with tacit or experiential knowledge to construct their professional identities.

Tacit knowledge is described as an 'intuitive knowing' (Malterud 1995); an embodied knowledge and 'understanding without a rationale' (Benner and Tanner 1987:23), that is implicitly developed during practice (Herbig, Büssing and Ewert 2001). Indiana is one CCN who alluded to the development of tacit knowledge and how it influenced her decision-making processes as a CCN:

*You learn to see when something's different, something's changed. It doesn't have to necessarily be something bad but you notice that it was different to the way it was before and then investigating it' (Indiana).*

Here, the more experienced Indiana explains how she perceives tacit knowledge as integral not only to her recognition of signs of changes in her patients, but whether such changes are worthy of her direct action. Her words capture the experiential nature of tacit knowledge as being developed through hands-on practice, rather than being specifically transmitted from theoretical knowledge and university education, and how she has learnt to recognise important, yet not necessarily measurable

indicators, of change her in patients. The experientialism of tacit knowledge is illustrated by Gaynor as she discussed her nursing experience during her tea break. Note how the hospital-trained CCN constructs her tacit knowledge in opposition to university-trained CCNs:

*Gaynor explains 'good nursing is about recognising when your patient has gone pear shaped; you don't know why and you can't explain it. Their obs [observations] are fine and the doctor's not worried, but you know they're just not right; you don't learn that at university!' (CCNG3002).*

In voicing, 'you don't know why and you can't explain it', Gaynor epitomises Polanyi's (1966) conceptualisation of tacit knowledge as that which cannot be articulated in an explicit manner and cannot be taught. It is something that 'you don't learn [...] at university!' This inability to explain a particular form of knowing is also evident in Indiana's explanation of her actions:

*I ask Indiana about the emergency that has just occurred. I enquire, 'How did you know something was happening with the patient?' She smiles and blushes and pauses for a moment before she answers, 'I not sure really', she shrugs her shoulders. 'Well I know the CCN who's looking after her; I know she is experienced. I looked over and saw a concerned look on her face...I just knew' (CCNI3207).*

These quotations from Indiana and Gaynor and the fieldwork extract, typify CCNs' application of tacit knowledge within their practice, particularly by more experienced informants. They reveal CCNs'

possession, development and application of tacit knowledge informs their professional identity constructions. While participants underscore the possession of the theoretical, technical and tacit knowledge in their understandings of their professional identities, it is also accepted that CCNs' possession, transmission, and their application of these knowledges within their practice, are subject to the legislative and ethical frameworks of the profession, and the procedures of the hospital and the ICU.

### **Procedural knowledge**

CCNs' practice was additionally guided by the procedures and protocols of the ICU, and the hospital more broadly. This involved the application of procedural knowledge, such as that associated with patient discharge.

Edwin explained to his nursing student one morning:

*'As the patient is being transferred to the ward to be discharged from the hospital later on in the day, we may as well organise the bits that come with that'. He counts of the tasks one at a time on his fingers, 'MRSA swabs, discharge summary, prescription, transport request' (MJB1101).*

In the above interaction, Edwin takes the opportunity to transmit his procedural knowledge within the hospital to his nursing student.

Transmission of theoretical, clinical, technical, procedural and legal knowledges are integral to the hospital context interactions between CCNs and their nursing students. Transmission of knowledges from senior to

junior staff, and from staff to students are significant in the development of professional identity, as it contributes to acquisition of not only clinical knowledge, but also of the nurses' professional role, nursing's cultural values, and the 'technological mastery' that are specific to critical care nursing (Brown, Stevens and Kermode 2012; Little 1999; 2000).

Furthermore, knowledge transmission is central to all nurses' integration into organisational environment of the employing organisation, specifically that related to hospital procedures and protocols.

The procedural framework of the hospital frequently intersected with other aspects of CCNs' knowledges, such as the knowledge of industrial legislation associated with patient ratios. For example:

*The shift co-ordinator... speaks to Indiana about...a patient...He asks 'do you think you can take him?' Indiana ...screws up her face and answers slowly, 'I don't know'. The shift co-ordinator... suggests a CCN 'can go home'. Indiana shakes her head, 'no he can't; I can't take anyone out of the unit'. She leans back in her chair, folds her arms across her chest, crosses one leg over the other glares at the shift co-ordinator. The shift co-ordinator... asks meekly 'can someone from days can come and special him (the patient)? Indiana shakes her head again...and drags the roster folder across the desk and flicks it open, 'I haven't got the staff'. The shift co-ordinator... asks, 'how many do you have?' Indiana taps her finger on the roster, 'I have 11, and I need 11'. The co-ordinator suggests 'I could always call someone in to special him on the ward'. Indiana nods and smiles weakly. The shift co-ordinator response curtly, 'well thanks, I'll see what I can do' and leaves. Indiana sighs heavily...and says under her breath, 'well he is a ward patient' (CCN12607).*

Here, Indiana would not compromise on the number of staff allocated to the ICU. While the shift co-ordinator attempted to find a solution to the issue of staff ratios in order to have a patient admitted to the ICU, Indiana's verbal and body language showed signs of disapproval and resistance as she emphasised the number of staff necessary to its functioning. This fieldnote extract additionally demonstrates how Indiana, as the CCNIC, has ultimate nursing control over the unit as she opposed the will of the shift co-ordinator (who holds the most senior nursing role in the hospital for the shift). In so doing, Indiana demarcated the ICU as her territory, and thus, acted to protect it from intrusion from nurses that are external to it (Baldwin 2007). (This territoriality also occurs between the CCNs and members of medical staff, and is detailed on page 177 of Chapter Six, 'CCNs' knowledges and Inter-professional Interactions'). Further, these fieldnotes captured Indiana's negative attitude toward making staff available to nurse 'a ward patient', when pushed by the co-ordinator. Indiana seemed reluctant to make compromises on staff numbers, and thus, enable the patient to be admitted. This suggests that particular patients are constructed as more deserving of the specialist practice of CCNs over others. (This is further discussed on page 262 of Chapter Eight, 'Professional Development').

Procedural knowledge also intersects with theoretical knowledge within the ICU as it was often underpinned by empirical evidence. In the following example, Gaynor explained the place of evidence-based theoretical knowledge in the establishment of infection control policies within the unit:

*Gaynor stands at the end of the bed and watches her Nursing Student; she points explains to me 'we change the [Intravenous] lines every four days to prevent infection...we used to change them every 72 hours but a new study has found every 4 days is better; but the protocol changes from hospital to hospital' (CCNG1501).*

## **Conclusion**

This chapter has examined the ways that CCNs structure the nursing knowledges that informs their professional identities. In exploring the five aspects of CCNs' knowledges; theoretical, clinical, technical, tacit and legislative/ethical/procedural, it became apparent that they are crucial to CCNs' interpretation and autonomous performance of tasks within their jurisdiction. Moreover, participants' knowledges are integral to constructions of difference and processes of inclusion and exclusion that informed their professional identities. CCNs' professional identities are constructed through identification of presumed difference in meanings

and knowledges between themselves, other nurses, the nursing profession more broadly, and other health professions.

Being a CCN is seen as different when compared to not only other health professions, but other nurses. CCNs value specific knowledges within their practice, and while some aspects are common to nursing generally, others are unique to CCN practice more specifically. These knowledges are essential to participants' perceptions of themselves as CCNs, members of the nursing profession, and shared understandings of actions, language, rituals and application of artefacts of their practice. It is the commonality of nursing knowledges, and their centrality to CCN practice which binds participants together as members of a culture-sharing group and, thus contributes to the processes of inclusion and exclusion that underpin professional identity constructions.

CCNs' knowledges are located in a knowledge hierarchy that extends beyond the ICU to include the hospital and broader society. (This is discussed in more detail in the following chapter, 'CCNs' Knowledges and Inter-professional Interactions'). Moreover, a hierarchy exists within nursing knowledges, as CCNs award value to particular aspects over

others. The prioritisation of 'academic ability' (Gaynor), 'higher understanding' (Donna), and a 'very strong knowledge base', over learning about 'fold[ing] a bed (Gaynor) or the correct way to face 'an open end of a pillow slip' (Donna) demonstrates the value CCNs' attach to theoretical knowledge over the instrumental knowledge-base of traditional nursing education and training. Yet, there are also evident contradictions of the significance of theoretical knowledge to CCNs' practice, and these reflect its disparate valuing within professional identity constructions.

Theoretical knowledge is inseparable from clinical knowledge, and the synthesis of both is fundamental to the performance of key tasks within CCNs' jurisdiction. This includes performance and interpretation of patient assessment and the delivery of basic care, the transmission of knowledge to CCNs and other health professionals, and the undertaking of nursing and medical interventions. CCNs emphasise the 'depth' (Nina) of their clinical knowledge and their autonomy to differentiate themselves from, and thus exclude nurses outside the ICU. Thus, they construct CCNs as a distinct social collective in which shared similarities inform their construction of professional identities. This similarity of perceptions between CCNs' understandings is suggestive that they are a cohesive



group. Yet their valuing of particular knowledges between themselves indicates intra-professional processes of difference that would suggest otherwise (This is explored in more depth in Chapters Seven, 'CCNs' Intra-professional Interactions' and Chapter Eight, 'Professional Development').

Technical knowledge or technological competence is necessary for participants' maintenance, application and interpretation of routinely used technologies within in the ICU: 'the ventilator' (Nina; Karla; Penny), 'monitor' (Nina) and 'the dialysis machine' (Penny; Karla). Technical knowledge is distinct to CCN practice and as such, participants employ it to draw jurisdictional boundaries and marginalise medical practitioners and other health professionals. The application of technical knowledge is gendered; although CCN practice involves a high reliance on technology, female participants denied it was central. Rather, they echoed Nightingale's (1969) assertion of nursing theory's focus on holistic care by identifying 'good quality...basic nursing care' (Gaynor) and 'hygiene care, mouth care, eye care' (Karla) as more salient. Moreover, female CCNs' provision of holistic care was evident in instances participants mediated between the technology, the patient and their significant others. Male

CCNs, however prioritised technology over holism, and thus contributed to the differential valuing of theoretical knowledge.

The application of tacit knowledge by the more experienced CCNs suggests that it has been developed through practice. Their recognition of 'something's different, something's changed' (Indiana), and 'you can't explain it' (Gaynor), was underpinned by experiential knowledge that had accrued through their extensive years of practice, rather than through formal learning. Tacit knowledge does not exist in isolation, but it is informed by the application of theoretical and clinical knowledges throughout a nursing career. CCNs' application of tacit knowledge moved beyond the technicality of established protocols and enabled autonomous management of highly uncertain and thus, indeterminant aspects of their practice.

The practice of all CCNs is ultimately guided by the legislative, ethical and procedural knowledges of the nursing profession, the hospital and the ICU. While legislative and ethical knowledges are transmitted at university, the procedural knowledge of the hospital and ICU are transmitted to nursing students while on practicum, and this knowledge

transmission makes a significant contribution to CCNs' professional identities. The empirical bases of protocols within the ICU also reinforce the systematic basis of nursing knowledges that underpin claims to professionalism.

The chapter reveals the significance of nursing knowledges to CCNs' meaning making within their practice and the construction of jurisdictional boundaries between themselves, other nurses and other health professionals. The chapter hints at further ambiguity of CCNs' professional identities that arises from their knowledges being central to both inclusion and exclusion processes between them as a group. This is taken up in the next two chapters where I move to analyse how CCNs' knowledges are integral to their negotiation of jurisdictional boundaries between themselves, Allied health professionals and medical practitioners.

## CHAPTER SIX

# CCNs' Knowledges and Inter-professional interactions

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### **Introduction**

The previous chapter focused on CCNs' knowledges as a significant aspect of their professional identity. It showed that these knowledges are integral to professional identity construction as they underpin both the shared meaning making processes of their practice, and the strategies of inclusion and exclusion that are utilised to demarcate professional boundaries.

The ICU is a practice area characterised by collaboration between CCNs and medical practitioners (Baggs and Ryan 1990; Chaboyer and Patterson 2001; Rose 2011). As such, in this chapter I explore the meanings and knowledges that inform CCNs' professional identities through a focus on boundary work within the collaborative processes that are central to their practice. Within these interactions, CCNs' professional identities are confirmed and challenged through construction and valuing of specific meanings and knowledges, and thus, including and excluding participants.

The chapter demonstrates that interactions between CCNs and other health professionals are highly contextual. Contextual factors include seniority and gender of staff, spatial and temporal dimensions in which interactions occur, and dominance of the medical profession. Such influences contribute to a continual shifting and reshaping of jurisdiction boundaries between professions (Abbott 1988; Nancarrow and Borthwick 2005). As such, CCNs must negotiate the boundaries of their practice roles in response.

The chapter begins by exploring CCNs' perceptions of the environment of the ICU and the blurring of jurisdictional boundaries as a consequence of inter-professional collaboration. Inter-professional interactions are then explored through a detailing of the spatial and temporal dimensions of CCN practice. A discussion elaborates on the influence of temporality on CCNs' passive and active collaborations before consideration of inter-professional conflict. Throughout, I consider the contextual valuing of nursing knowledge and practice within a hierarchy of knowledges, and how the nature of interactions within and across jurisdictional boundaries can contribute to an ambiguity of CCNs' professional identities.

## **Inter-professional collaboration**

The majority of informants identify the ICU as characterised by collaboration between CCNs, medical staff and Allied health professions. Such collaboration is conveyed through narrating the interdependence of medical staff, Allied health professionals and nursing staff within the unit, as in the following example:

*We're quite reliant on each other, especially with the more junior physio [therapist]s and residents and things coming through. They're very reliant on us to help fill them in on the patient's situation... the doctors are reliant on us; we're reliant on doctors and the same with the physio [therapist]s (Karla).*

The utilisation of the term 'we' to refer to CCNs is indicative of an awareness of collective identity as a member of both a culture sharing group (CCNs) and a team endeavour within the ICU (Henneman, Lee and Cohen 1995). The word 'reliant' in relation to the CCNs, physiotherapists, and doctors additionally conveys interdependency, partnership and exchange processes between these groups. Further, the reference to 'fill them in on the patient', implies processes of knowledge exchange between the professions of nursing, medicine and Allied health. This signifies the themes of power-sharing and knowledge exchange associated with collaborative practice (Lingard et al. 2004).

Exchange and sharing are exemplified in the routine activity of ward rounds and the management of critically ill patients inside the ICU. My fieldnotes describe collaboration between CCNs and medical staff during an emergency:

*The staff all gather around the bed as the Registrar and MOs [Medical Officers] call orders and ask questions, 'can you bring the intubation trolley over?' 'What rate are the fluids set at?' One of the MOs and a CCN collect the intubation trolley. Brenda checks the rate on the IV pump and calls '156mls per hour'. Brenda moves to suction the patient's airway; she asks the Registrar, 'Do you want you use sux [suxamethonium]?' A MO calls, 'can someone draw me up some sux?' Brenda choses an ampoule and checks it with the MO before drawing up the drug into a syringe, taping the empty ampule to the syringe and passing it to the Registrar. Hallam moves to suction the patient, and Edwin moves to his side and holds the patient's head. A MO calls 'I may need that Aramine'; he looks to Edwin, who goes to the trolley. The Registrar asks, 'what size tube have you got?' Hallam answers, 'I've got a 6; Is that alright?' (CCNE1111).*

Inter-professional collaboration is more likely in cases when patients are experiencing severe co-morbidities and in emergencies. In the following excerpts, collaborative efforts between Allied health professionals, CCNs and doctors are described by CCNs from the moderately and more experienced groups:

*There's more likely to be a lot of collaboration when the patient's extremely unwell... especially [with] a lot of social issues, or if there's...a long term patient that needs increased motivation...That's when us and the physio[therapist]s work very closely together; get him [sic] motivated, get him moving... And at the moment with another patient that we'll probably remove treatment from tomorrow... the social workers have been very closely involved with us at the moment to help support the family (Karla).*

*But usually it is [collaborative] if there's an acute event happening; it's collabouous [sic] because you just need help, need hands and need*

*assistance to do several things... when there's something going on you do work collaboratively with the doctor (Brenda).*

Here, the words 'extremely unwell' and 'removing treatment' signify the seriousness of the health conditions of the patients in the ICU. These examples additionally reveal the management of such critically ill patients incorporates collaboration between nursing staff, the physiotherapists, and the social workers. The claim 'you just need help, [you] need hands and need assistance to do several things', when managing an 'acute event', are important in two ways. First, it supports the claim of the serious morbidity of the patients within the ICU, and second, it indicates the necessity of collaboration in response to the critical nature of patients' conditions (Lingard et al. 2004; Miller 2001; Piquette, Reeves and LeBlanc 2009; Rose 2011).

This second point is further indicative of a 'blurring' of ownership over the professional jurisdictions between medicine, nursing and Allied health professionals (Nancarrow and Borthwick 2005; Tye and Ross 2000). What is telling is that this blurring does not always occur, but rather it is selective and specific, and while instances of inter-professional collaboration are more likely during acute events, these processes are also influenced by the spatial and temporal dimensions of the ICU.



## **Spatial dimensions of inter-professional interactions**

The CCNs participating in the study regard intra-professional collaboration as unique to the spatial dimensions of the ICU, as they perceive that such an approach does not characterise other nursing specialty practice. In the extract below, Hallam references spatial dimensions and the people and processes occurring within them, to distinguish the ICU as a space where inter-professional collaboration is a normative aspect of CCN practice:

*What characterises the doctors on the wards is autonomy and power; they like think they alone can be in control of the patient. Staff in here are used to working with one another... we are closer to the Consultants in here; on the wards you hardly see them, let alone speak to them (CCNH1503).*

In this fieldnote extract, Hallam engages in a process of difference to distinguish between two spaces-the ICU and the wards within the hospital - and associates each with staff's different approaches to health service provision; the ICU characterised by inter-professional collaboration and the wards characterised by medical autonomy (Chaboyer and Patterson 2001). In drawing attention to these differences, Hallam prioritises and attaches value to inter-professional collaboration within his practice, and his professional identity (Barth 1969; Jenkins 2014). The words 'closer to the Consultant' indicate the spatial arrangements of the unit within the hospital significantly contribute to perceptions of increased inter-

professional processes between CCNs and medical staff when compared to the ward (Chaboyer and Patterson 2001). That is, there is a requirement of close inter-professional work due to patients' needs which are specific to the ICU.

Therefore, the closed space of the ICU, and the severe morbidity of patients within, means that doctors maintain a continual presence within the unit. Furthermore, the complex medical needs of patients require doctors of specialities other than ICU, such as cardiac medicine and surgery, to attend the unit and interact with CCNs as they attend to patient rounds. This diversity of staff and expertise is significant to indicate spatially-influenced inter-professional collaboration. This is articulated by Indiana: 'I think you... have to work as a team. I mean nobody knows everything; we are all there to work together' (Indiana).

Inter-professional collaboration is further spatially influenced as it is more likely to occur within specific spaces of the ICU, and is based on CCNs and doctors' perception of ownership of these. One of the areas that CCNs consider to own is the bedspace. This is expressed by Karla when she speaks about the bedspace, 'this is my space and I'm professional about

it...my space is my space' (CCNK1915). Her reiteration and accentuation of the word 'my' as she describes the bedspace and relates her actions within it as being 'professional', reflects her understanding of her ownership and autonomous control of the area as an aspect of professional identity (Latimer 2003). Drawing on the concept of territoriality, both CCNs and medical practitioners distinguish spaces as their own, and each group acts to protect these from intrusion (Baldwin 2007).

CCNs' authority within the unit generally and within the bedspace specifically, is demonstrated by the way they direct auxiliary staff and family members during interactions in these areas. For example:

*Karla asks the ward aide 'would you mind giving me a hand to roll him [the patient] over? I know it's not your job'. The ward aide agrees and comes to join Karla at the bedside. She lowers the bedrail and tells the ward aide 'it shouldn't take much; perhaps if you turn him towards the TV and I'll slide a pillow in'. The ward aide turns the patient and Karla slides pillow behind the patient's back. She says 'too easy'. The ward aide looks at her and says 'is that it?' Karla replies, 'a-ha; I told you it wouldn't be much' as she lifts the bedrail back into place (CCNK1306).*

*Airlee walks over from the end of bed 8 to meet her patient's female relative before they reach her. She says 'hello again' and explains 'your mum will feel better now: we've just given her a wash, changed her linen and given her a fresh gown'. She back towards the bed and takes a chair from beside the overbed table and drags it up towards the head of the bed. She looks across to the visitors, gesturing with her hand and calling one by her first name. One relative takes a seat and leans in to hold the patient's hand.*

*Airlee then sets up a chair in the same position on the other side of the bed for the other woman and gestures to her (CCNC604).*

The authority CCNs have within the bedspace is additionally indicated in the way Allied health professionals and doctors who are allocated to the ICU utilise the area. These health workers restrict their movement into the bedspace and allow the CCNs to direct their actions around the area. The following fieldwork notes describe this process:

*Edwin stands at the edge of the bedspace... when the social worker approaches... He moves away from the end of the bed and motions for the social worker to follow...Edwin explains, 'he [the patient] has frontal lobe confusion issues and is hyper-anxious...I'll introduce him to you'; he gestures with his hand for the social worker to move towards the bedspace; she approaches the patient (CCNE1101).*

*The MO [Medical Officer] approaches the bedspace and stands at its very edge. He asks Karla 'how's everything?' Karla comes to stand beside him, 'I've just done his neuro[logical] obs[ervations]...' The MO gestures towards the patient with a nod of his head and Karla nods back. The MO nears the bed and speaks loudly to the patient. The doctor asks Karla, 'how's his chest?' She shakes her head and gestures to the patient with her hand. The doctor removes his stethoscope from around his neck and listens to the patient's chest (CCNK1908).*

In these interactions, neither the social worker nor the doctor ventures past the edge of the bedspace without implicit or explicit direction from the CCNs. In the first passage, the movement of the social worker is explicitly directed within the unit generally, and toward the bedspace specifically. Similarly, in the second passage, the doctor waits on the edge of the bedspace while he discusses the patient with the CCN. When he

does moves to interact with the patient, he implicitly requests the CCNs' permission with a nod, and agreement is signalled in the same manner. In both cases, body language is a significant indicator of CCNs' authority over the bedspace and access to the patient's body, and the social worker's and doctor's acknowledgement of the bedspace as an area that they require permission to enter.

The value that CCNs attach to ownership of the patient and bedspace as an aspect of their professional identity is manifest in situations of conflict when such control is not acknowledged by other health professions. This is most often the case when visiting doctors perform rounds of their own patients within the unit. The following passage describes this process between Gaynor and the visiting surgical team:

*The Registrar stands at the end of the bed and watches as his resident removes the dressing from the patient's foot. Gaynor turns around and sees the doctors in the room. She looks from them to the patient's exposed foot, to the bandage on the floor, and then back; her eyes widen and her mouth gapes. The Registrar asks, 'can you just take this dressing off for us so we can have a look'. Gaynor shakes her head as she removes the dressing and picks up the dirty bandage from the floor and puts it in the bin. She puts her hands on her hip and tightens her mouth. She looks at the MOs [Medical Officers], 'so are you the surgical team?' The Resident answers, 'yes this is [first name] and I'm [first name]; we are the Registrar and Resident for [Consultant's name]'. Gaynor introduces herself and then turns to look up the bed and addresses the patient by his first name, 'the surgical doctors are here to see you' (CCNG2004).*

Here, tension arises because the doctors fail to engage in the normative processes associated with the utilisation of space within the unit. They do not request entry to the bedspace, nor do they acknowledge the presence of the patient or the CCN. Rather, they move to assume control of the area and patient through their removal of the dressing and the Registrar's directing of the CCNs' actions. The CCN responds in two ways. First, she signals her displeasure at the doctors' control of the area through her body language (shaking her head and tightening her lips). Second, she moves to correct the power imbalance through asserting control over the area. She achieves this through disposing the bandage, forcing an introduction from the doctors, and speaking to the patient on the doctors' behalf. These actions imply a resistance to the doctors' own perception of control, and thus are indicative of the CCN's construction of ownership of the bedspace and patient as part of her professional identity. Furthermore, the interaction suggests what constitutes the professional identities of other health professionals, specifically doctors. For example, the doctors create social distance between themselves and the others in the room, and assert their control over staff and patients within these spaces (Freidson 1970a; 1970b; Johnson 1972). As noted earlier, however the collaborative environment of the ICU can challenge these norms and roles, and thus present problems to professionals who maintain medicine's dominance.

The perception of control over specific spaces within the unit presents collaborative challenges to CCNs and doctors. This is particularly the case in the OA (Observation Area) that is constructed as the 'doctors' space'. The following excerpts outline common interactions between medical staff is commonplace in this area, which entail a range of professional exchanges:

*The Registrar and a Medical Officer sit on the doctors' side of the OA as they discuss the newly arrived patient's operation, current condition, and ensure all medical orders for the operating theatre. The Registrar asks about the patient's antibiotic, and suggests the MO look in the patient's chart to 'find out the type and dose that she's had'. The pair shuffle through the documents and patient's notes on the bench in front of them (CCNA101).*

*In the OA, the Consultant, the night shift Registrar, the early shift Registrar, a Medical Officer and an Intern sit on the doctors' side of the OA casually lounging in chairs. The Consultant explains how travel and meal entitlements can be tax deductible while the others listen and nod along. When he finishes talking the night shift Registrar straightens himself up and says, 'I'll be off then'. The others say 'goodbye' with waves and nods of heads. The Consultant begins to give handover to the other doctors (MJB2901).*

Exchanges between medical staff and CCNs within the doctors' side of the OA involve CCNs approaching the area for knowledge exchange, particularly the reporting changes in their patient's conditions. For example:

*Gaynor walks across the Observation Area to the Registrar seated on the doctor's side. She stands next to him and waits from him to look up from his laptop; he looks to her. She tells him in a flat tone, 'the patient in 9 has a*

*temp; it's 38'. He doesn't turn to look at the patient but says, 'but that's down from 39; he's been febrile all afternoon', and gives a dismissive wave with his hand...Gaynor nods and leaves the Observation Area and the Registrar looks back to his laptop (CCNG1201).*

On this occasion, the Registrar is not concerned with information that the CCN has provided to him. This is demonstrated in his transmission that is already aware of the patient's temperature ('he's been febrile all afternoon') and his dismissive wave. The CCN signals her agreement with a nod of her head and returns to her patient. In instances when doctors consider the information provided by CCNs to be significant, they leave the OA to work collaboratively with CCNs to ensure necessary medical interventions:

*Airlee's patient wakes up suddenly and begins to toss her head around from side to side. Airlee moves... to the side of the bed and touches the patient's shoulder, 'you're alright...' The patient becomes more unsettled ... Airlee asks 'are you in pain?' and the patient nods. Airlee tells her, 'I'll organise something for you'. Airlee speaks up and across the wall of the Observation Area to the Registrar...'I need someone to write up some analgesia for a patient with chronic pain issues'. He asks 'what type?' ... Airlee informs him '[for] osteoarthritis'. He nods and comes down to the overbed table at the bedside (CCNA607).*

In the above fieldnotes (observations CCNG1201 and CCNA607), the CCNs access the Registrar while he is located in the doctors' side of the Observation Area. While one directly enters the area, the other speaks to the doctor across its periphery. In each case, it is the doctor's assessment of



the knowledge provided by CCNs that influence their movement from the OA to the CCNs' area of the bedspace. While medical staff do not always move from the Observation Area on the basis of knowledge exchange with CCNs, they do not question the direction of other, often more senior, medical staff when the latter are located outside the Observation Area:

*Hallam speaks to the Registrar who is at the sink next to the bedspace scrubbing up and explains his patient's lowered oxygen saturation levels. The Registrar calls to the MO [Medical Officer] in the Observation Area 'can you have a look at [patient's surname] chest x-ray?' The MO does so and approaches the end of the bed where he tells Hallam 'I'm not real sure why his [sic] sats [oxygen saturation levels] are dropping; there is no pneumothorax on the x-ray' (CCNH1901a).*

Here, the CCN takes the opportunity of the Registrar's proximity to the bedspace to inform him of the patient's lowered oxygen saturation level. The Registrar's consideration of the knowledge offered by Hallam as significant leads him to direct the more junior Medical Officer. The Medical Officer follows the Registrar's direction, and attends the bedspace to discuss the patient. The actions of the Medical Officer suggests that it is doctors' decisions to leave the OA, rather than CCNs' direction of them within it, that shapes collaboration. As such, movement to and from the OA is promoted by knowledge exchanges that occur between CCNs and Medical Officers.

In cases where CCNs approach medical staff within the Observation Area to request knowledge that is otherwise accessible, the doctors make a point of directing them to the information. This occurs when Airlee approaches the Registrar sitting on the 'doctors' side' of the OA:

*Airlee flops into one of the chairs at the rear of the doctors' side and looks over to the two Registrars. She asks loudly, 'what's a vertebral contra-coup?' The male Registrar slowly raises his head from the book in front of him and points to a thick medical text, 'you can look it up in that book' (CCNA0107).*

This exchange further indicates that collaboration breaks down in certain spaces where professional identity work and the demarcation of specialty knowledges are emphasised to highlight differences. In this case, the differences between the two professions can be read as lying in not only in specific knowledges, but also in associated power differentials by which the doctor's knowledge is constructed as the more legitimate within the medically dominated environment of the ICU (Freidson 1970a; Jenkins 2014; Stein-Parbury and Liaschenko 2007). In this case, the doctor's refusal to share his knowledge distinguishes him, which he achieves by excluding the CCN from easily accessing it, and, it symbolises an in/out group process (Jenkins 2014). This implies that control of particular spaces facilitates not only identification of one's own professional identity, but also that of others (Freidson 1970a; 1970b). Spatiality is not, however, the only influence on inter-professional collaboration, conflict, and control

that inform the CCNs' professional identities. Temporality provides another level of complexity to these processes.

### **Temporal dimensions of inter-professional interactions**

In addition to spatial considerations, the modes of inter-professional collaboration exhibit temporal dimensions, which are differentiated across the nursing three shifts in the ICU. While inter-professional collaboration occurs readily between CCNs and senior and junior doctors across the early and late shifts, collaboration between CCNs and Allied health professionals are confined to the early shift. In contrast, inter-professional collaboration on the night shift occurs between CCNs and Registrars (and Consultants in exceptional circumstances, such as admission of an after-hours private patient). The differences in inter-professional collaboration between the three shifts can be understood through the temporal structure of activities within the unit (Reddy, Dourish and Pratt 2006:41). From this perspective, each nursing shift can be seen to represent a large scale temporal rhythm, and each of these is temporally structured by the finer grained temporal rhythms underpinning them.

An example of a finer grain temporal rhythm that structures the large scale rhythm of the CCNs' early shift is the formal ward round at 8am

daily. Ward rounds involve the ICU doctors of various ranks (including Consultants, Registrars, Residents and Interns) and Allied health professionals visiting each patient to discuss their condition, evaluating current treatment, and deciding upon future courses of action. Gaynor identifies each member attending the 8am ward round as they gather around the end of an adjacent bedspace:

*I call them the gaggle... other than [CCN In-Charge's first name] there's the two physio[therapist]s who are dressed in all navy; the guy in the light blue shirt is from pharmacy, the other guy is [first name], he's one of the ICU Consultants and he's a Registrar, and the female is one of our senior Residents (CCNG2108).*

The description of 'the gaggle' is also captured in my fieldnotes:

*Inside room 3, six doctors stand with the CCN around the end of the bed; Donna tells me that they are the 'surgical team'. When they leave the room they file out one by one in what looks like most junior to most senior (based on age). The youngest looking doctor (the Intern) emerges first with the patient's notes folder open in one hand as she writes in them. She puts the folder on the overbed table as the other doctors (except the oldest looking) gather in a group around her. When the oldest looking doctor emerges from the room, the others fall in behind him and then file out from most senior to most junior (MJB3001).*

My fieldnotes illustrate that while ward rounds are conducted across all shifts, these are differentiated by the seniority of the doctors involved. Junior doctors such as the Resident and Intern conduct less formal mid-morning rounds while the late shift rounds are attended by a Registrar, who is sometimes accompanied by a junior doctor. In contrast, the night shift rounds are undertaken by a Registrar only. Across all shifts,

participants' involvement in ward rounds takes two central forms; CCNs either cease activity within the bedspace and join the others at the overbed table at the end of the bedspace; or continue working. In both cases, CCNs are either passively or actively involved, and this is dependent upon the interrelatedness of the seniority of both the CCNs and doctors, and the temporal dimensions of the interaction.

### ***Passive collaboration***

In the case of passive involvement, CCNs offer information only when requested. This request generally comes from the most senior medical officer, the Consultant. Passive collaboration characterises interactions between CCNs and the Consultant during formal 8am ward rounds, and is a frequent feature of late and night shift rounds when patients' conditions are stable. The following passage describes a passive form of interaction between Edwin and five doctors on the formal morning round;

*The Intern looks at the patient's chart as Edwin moves across the bedspace to stand next to him. The Consultant, his two Registrars and Resident come and stand around the intern. The consultant asks the other doctors, 'what's happening with his insulin?' The Intern answers, 'it's being reviewed'; the doctors discuss the patient's insulin levels between themselves... The Consultant asks the doctors, 'how long has he been here?' The MOs [Medical Officers] look blankly at one another and then to Edwin. Edwin looks across to the Consultant and says, 'he's day 10'. The Consultant asks Edwin, 'does he have a CV [Central Venous Line]?' Edwin nods; 'he has a CV line and a PICC [Peripherally Inserted Central Catheter]'. ...The Consultant nods and leaves as the other MOs follow (CCNE2206).*

This interaction suggests the influence of medical dominance within the unit generally, and particularly during ward rounds in two ways. First, the exchanges are predominantly between the medical staff in the form of the Consultant requesting information from the less senior doctors and, second, the information exchange focuses almost entirely on biomedically based information or 'case knowledge' (Stein-Parbury and Liaschenko 2007:472). For example the Consultant and the doctors' conversation centres on the physiological medical concern of the patient's 'insulin levels'. Further, when the Consultant does address the CCN, he does so drawing on biomedical terminology to request information regarding the patient's CV, and the CCN reciprocates using biomedical terminology to report the patient 'has a CV line and a PICC'. This interaction indicates the high degree of value attached to case knowledge within the health care system generally (Turner 1987), and within the culture of the ICU specifically (Stein-Parbury and Liaschenko 2007). This means that what qualifies as relevant knowledges is contained within the roles of those involved. In in this case the medical staff, and the specific qualities of the fine grain temporal rhythm of 8am ward rounds occur. Knowledge and power relationships are constructed as normative within doctors' ownership of the ward round. In this instance, Edwin's professional identity as a CCN is informed by the role of case knowledge 'information giver' (Manias and Street 2001b:446) when instructed to do so when the

doctors' knowledge of the patient is limited. Thus, Edwin's knowledge is on an 'on call' basis; only required when it is requested overtly. This highlights the importance of the different knowledges required by CCNs.

While it may seem that the doctors dominate the above interaction, the CCN's knowledge of the patient enables him to engage actively in the ward round. In addition, the provision of knowledge in a quick and efficient manner, where the medical team need to review a number of patients in a limited timeframe, is suggestive of an awareness of the temporal constraints of the morning ward round. The CCN's movement towards the group and his contribution within it, are representative of Hill's (2003) theme of 'being there' in an action-based sense. In moving across the bedspace to gather with the group, Edwin asserts himself to actively move from the 'periphery' to 'break through the inner circle' of medical practitioners (Coombs 2003:131; Hill 2003:232). These actions indicate Edwin's membership of a team endeavour, despite his role being passive and inferior.

### ***Active collaboration***

Active inter-professional collaboration between senior CCNs and Consultants characterises the early shift in the form of knowledge

exchange. This is because the large scale temporal rhythms that constitute Consultants' regular working hours correspond to the temporal dimension of the early, as opposed to the late and night shifts. This exchange of knowledge is demonstrated in the following passage:

*'(Patient in bed 2's name)'s mother want her to go home... she thinks she is only getting sicker while she is here... and I agree with her'. A thoughtful look crosses the Consultant face. He replies, 'okay then...'. The CCN In-Charge smiles (MJB1501).*

Here, the CCN In-Charge draws on 'person knowledge' in opposition to 'patient knowledge' and 'case knowledge' (Stein-Parbury and Liaschenko 2007:472), to contribute to decision making regarding the patient's discharge. The In-Charge's input illustrates that CCNs are working beyond the biomedical model to incorporate a wider range of social knowledges sensitive to the patient as a person. The CCNIC's contribution and Consultant's consideration of person knowledge within collaborative decision making, signifies the high value CCNs place upon personal knowledge above case knowledge within their professional practice, as suggested by Stein-Parbury and Liaschenko (2007). The interaction between the CCN and senior doctor also highlights the different, yet complementary, forms of knowledge underpinning the professions of nursing and medicine. This suggests this particular CCN's professional identity is underpinned by her holistic understanding of the patient as a



person, and this is confirmed by the Consultant's consideration. The value of the CCNIC's input is indicated by the Consultant's acceptance of the information she has contributed and his agreement ('okay then').

An active form of inter-professional collaboration on the early shift also involves CCNs and junior doctors, which is most evident during the mid-morning round. In these interactions, junior doctors such as Interns, Residents and less experienced Registrars are reliant on knowledge provision from CCNs. This is the case with Donna and a new Intern as the doctor performs mid-morning rounds:

*The Intern asks, 'what's the patient's diagnosis?' Donna answers 'community acquired pneumonia'. The Intern looks at the patient's chart, places it down and begins to walk away from the bedspace. Donna calls him back and directs him away from the bed and speaks to him inaudibly. They both nod. Donna thanks him in a loud voice as she smiles and moves back closer to the bedspace. She tells me, 'I told him about the NFR [Not For Resuscitation Order]; the family are coming back; he's said he's gonna talk to them (CCND3001).*

Here, the Intern's reliance on Donna's knowledge of the patient corresponds to the earlier cited emphasis (see page 207) on inter-professional knowledge sharing as a significant process in the ICU. In asking Donna for case knowledge of the patient, in the form of diagnosis, the Intern indicates that his knowledge is limited. She confirms her case knowledge with her answer (community acquired pneumonia). This is

important because it is the responsibility of the junior doctor to transmit knowledge of the patient to the Consultant.

Donna also goes beyond the Intern's request of case knowledge. She exhibits concerns that the patient is in the ICU, as the patient's notes indicate his wishes to be neither admitted to intensive care, nor be resuscitated in the event of an emergency. While this is documented in the patient's notes, contrary to his wishes, he has been both resuscitated, and admitted to the ICU overnight. In response to this, the CCN draws on patient and person knowledge to advocate for the patient and to direct the Intern's activities to discussing this matter with his family. In this case, the Intern places value the CCN's active contribution; this is indicated in his agreement to follow her request. This serves to confirm Donna's role as a patient advocate as part of professional identity (Cook, Gilmer and Bess 2003; De Araujo Sartorio and Pavone Zoboli 2010; Water et al. 2016). In doing so, she demonstrates her knowledge of the boundaries between the two professions and goes beyond information required as this is integral to her role.

In contrast to doctors' valuing of CCNs' knowledge on the early shift, doctors on the late shift tend to devalue CCNs' active contributions, particularly in cases where the patient's medical condition is stable. This is the case when Karla engages with a sole female Registrar performing rounds one late shift:

*The Registrar approaches Karla at the overbed table at the end of bed 8 where she says, 'hello' to Karla and... greets him [the patient] by name. The Registrar asks, 'How is he?' Karla replies, 'As you can see, he's well'. The registrar looks to the patient's unrestrained arms. Karla says, 'Yes; he hasn't grabbed at the tubes'. Karla goes on, 'I think he's probably pretty bored. I need to find out what he does for entertainment... games, TV, toys?'...The Registrar nods and moves along to the next bed (CCNK1305).*

The CCN's concern with her patient's boredom indicates her constant presence with the patient as a nurse locates her in a position where she can ascertain specific knowledge about him not available to medical practitioners. The Registrar's lack of verbal response to the CCN's expression of concern for her patient's social needs indicates she sees it of little consequence to the patient's overall medical condition and treatment. Note that the Registrar does not dismiss Karla's contribution rather, she sees it as irrelevant to her practice of medicine.

The Registrar's central concern is the patient is no longer compromising his medical state through disconnecting the ventilator tubes from his artificial airway and thus, risking his immediate respiratory health. Once the doctor is satisfied of the patient's respiratory function, she moves on, which indicates that it is not the focus of the Registrar to think about, or manage the patient's boredom.

The Registrar's lack of verbal response to the CCN's input can be related to the high value doctors attach to the priority of case knowledge at the expense of patient and person knowledge (Stein-Parbury and Liaschenko 2007). Coombs (2003) argues that such lack of acknowledgement of the significance of nursing knowledge, negatively influences nurses' experience of their professional identity within ward rounds. Yet, patient and person knowledge are valued by some medical practitioners as demonstrated by the concern shown by the Consultant and the Intern to the contribution of such knowledge by the CCNs (as seen on pages 224 and 226).

This indicates the value that doctors attach to case, patient and person knowledge is differentiated between the large scale temporal rhythms of

the early and late shifts, and the seniority of staff involved within each shift. The presence of the Consultant on the early shift necessitates a higher exchange of case, patient and person knowledge, as they are the central decision maker during this time. In contrast, the role of the Registrar on the late shift is one of maintenance, and thus only case knowledge is valued.

Active collaboration between CCNs and doctors on the late and night shifts is common. This is because the doctors who are rostered on these shifts not only tend to be less experienced, they are also limited in their ability to glean information from medical practitioners due being the only doctor in the ICU and one of few within the hospital. As a consequence, CCNs are often required to offer advice and guidance in situations when the doctors are challenged in making clinical decisions on patients' treatment. The following passage describes an interaction on a night shift in which moderately experienced Karla, working as CCNIC, collaborates with a Registrar as she prompts him to decide on further treatment after his prescribed treatment has no effect:

*The Registrar looks blankly at the monitor for a moment before Karla approaches closer to him and asks calmly and quietly, 'what meds do you think we might need if this happens again?' He half smiles, 'I'm not sure'. Karla smiles, 'well why don't we go up and have a chat about it', as she guides him towards the OA [observation area] (CCNB1719).*

In this interaction, the CCN's actions highlight nurses' 'knowledge as a source of survival for doctors' (Manias and Street 2001a:133). In contributing knowledge to the doctor's decision making, the CCN negotiates the professional boundaries between nursing and medicine's authority and power over nurses and patients upon treatment failure. Such negotiation is representative of professional identity as informed by knowledge and power sharing with medical professionals in collaboration, as well as care for the patient (Apker et al. 2006; Nugus et al. 2010). The equality between the two health professionals is also highlighted in the way Karla does not undermine the medical professional, but moves him away to the Observation Area, with his willingness to follow indicating the value he places on nursing knowledge and experience in the collaborative process.

Active collaborations between CCNs and Allied health professionals are a feature of the early shift due to the intersection of the large scale rhythms with this shift. These active interactions are based on Allied health professionals' heavy reliance on, and active seeking of CCNs sharing of knowledge. Physiotherapists are the most present Allied health profession within the ICU, attending to both 8am rounds as well as their own rounds,

and performing their professional activities. During rounds they are dependent on the bedside CCN's assessment of the patient to decide on future treatment:

*Two physiotherapists approach Fern at the bedside. The male asks Fern, 'how was your patient's night?'... Fern replies 'I really need your help today... I just listened to his chest and it's sounding heavy'. The male physiotherapist nods... Fern goes on, 'I don't want it [the patient's chest] getting grotty; he really needs to get up'. The physiotherapist smiles and says, 'yeah sure... when's good?'... Fern smiles and says, 'well I'll be about an hour'. He nods 'we'll be back in one hour' (CCNF2307).*

Here, the characteristic collaborative elements of reliance ('I really need you') and knowledge exchange ('his chest is sounding heavy'), are present as the CCN directs the actions of the physiotherapists. This direction occurs through negotiation rather than domination despite the physiotherapists' higher status within the hierarchical organisation of health care. Such an exchange implies the power differentials between CCNs and the physiotherapists, as Allied health professionals, are more equal than those of CCNs and doctors (Reeves and Lewin 2004b). While Allied health professional are awarded higher status than CCNs within the hierarchical organisation of hospital, the cordiality that accompanies exchanges between them arises from both receiving their orders from doctors and, thus the two groups perceive themselves to be of equal standing as health professionals.

CCNs acknowledge collaboration with physiotherapists is particularly important, as they can incorporate activities from the Allied health professional's jurisdiction into their own scope of practice as Nina describes:

*When you're...there with the physio[therapist]s you see how that person moves, how safely they get out of bed, how short of breath they get when they move,...how much pain have they got,... what are they able to do. And then on the weekends when the physios aren't there you can document, oh we did this with the physios, it was really safe, this is a good way to get this person out of bed (Nina).*

Collaboration with physiotherapists draws attention to how the jurisdictions of CCNs and Allied health professionals can and do overlap temporally. In the above example, the CCN delineates the boundaries between nursing and physiotherapy, noting that patient mobilisation falls within the latter's jurisdiction, while patient assessment ('how' and 'what') is located within her own. She then describes these boundaries shift across temporal dimensions, such as 'on the weekends' when the 'physios aren't there'. Furthermore, the CCN alludes to care when she identifies patient assessment as a central task within her own jurisdiction, and conveys legislative concerns in the lexicons of 'document' and 'really safe'. This offers insight into the salience of care, patient safety and accountability in informing CCNs' constructions of professional identity (Cook, Gilmer and Bess 2003).



## Inter-professional conflict

Inter-professional conflict is manifest when CCNs approach Interns, Residents Medical Officers, and Registrars, to express concerns with their patient's condition. The CCNs acknowledge conflict between themselves and the lower rank doctors, such as Interns and Medical Officers, and perceive that they contribute to the less experienced Medical Officers' knowledge development within the unit. This involves not only the transmission of clinical knowledge, but also knowledge that relates to the procedures and protocols within the organisational setting of the ICU. For example:

*Catrina asks the cardiology Medical Officer 'does this man have an appointment with the cardiology team today? The MO [Medical Officer] answers 'no; I told him that yesterday'. Katrina retorts 'no you didn't...you didn't write anything in the patient notes; so therefore it may as well not have happened; you know that'. The MO lowers his head and replies 'yes I know; I was going to come back today and'. Katrina cuts him off, 'if you were there yesterday and you weren't going to see the man today, what would've changed; you should have done it then' (CCNC0906).*

Here, Katrina confronts the MO for not meeting the legislative requirements of his practice. The MO in lowering his head subordinates himself to Katrina's rebuke. This indicates that CCNs' legislative and procedural knowledges endow them with authority over doctors when these requirements have not been met.

Conflict also occurs when CCNs perceive that elements of nursing knowledge are not valued, especially by less experienced doctors. Nina conveys this sentiment specifically regarding Grade 4 CCNs when she says, 'if this new doctor is quite inexperienced then...[they]would probably do better to listen to the nurses who have had 25 years of experience in ICU' (Nina). Indiana reinforces this view when she describes an ideal doctor as 'one that can make a good treatment decision...takes ownership of the patient and listens to us...or at least... ask if they don't know'(CCNI1812). Thus, inter-professional conflict can occur when collaborations with CCNs are not valued.

Observations of interactions between CCNs and junior medical personnel within the unit exhibit overt conflict in cases when the doctors fail to meet the expectations of CCNs. This includes doctors taking too long to perform routine tasks when there are more pressing matters, such as emergencies. This is the case when a patient becomes severely agitated one night shift:

*Brenda grabs her patient by both shoulders and calls to Karla, 'I'm gonna need help here'...Karla calls across the unit to the Registrar, 'if you've finished we need you here now'. She looks around to Brenda and another CCN and adds in a low voice, 'not at 2am' (CCNB1715).*

Karla's realisation of the need of the doctor's assistance without personally assessing the situation beyond Brenda's cry for help reflects her possession and employment of tacit knowledge within her practice (as described in the previous chapter). Moreover Karla's actions communicate her trust of Brenda's own nursing knowledge and experience. As in other cases of emergencies during the night shift, the CCNs assume authority over the attending doctor by directing their actions. While CCNs are willing to collaborate across the blurred boundaries of medicine as required, conflict arises when CCNs perceive that doctors are not practising within their own jurisdiction. This is evident in the following observation where the reference to 'Halo', refers to the drug Haloperidol:

*The Registrar comes across; Karla asks him, 'Halo?' He nods. Karla asks, 'how much?' The Registrar asks Karla, 'how much do you think she [the patient] weighs? Fifty? Sixty kilos?' Karla confirms, 'yeah about that'. The Registrar... asks, 'what would you normally give as a stat dose?' Karla glares at him; he drops his head quickly and says, 'I'll go work it out'....Karla goes on to deliver the drug. The Registrar returns; Karla tells him, 'I'm giving her 75 micros'. The Registrar nods and says, 'yes that's what the prescribing guide recommends; I'll write it up in her chart' (CCNB1715a).*

In this exchange, Karla indicates her own clinical knowledge through the delivery of the correct dose of the drug without the authority of the doctor. Furthermore, CCN's knowledge is suggested in the doctor's line of questioning of Karla. Yet, in this circumstance Karla refuses to share her knowledge as the responsibility of the drug calculations belongs with the

doctors. While Karla's actions reflect the necessity of CCNs to undertake autonomous decision making in emergency events (Hughes 1988; Tye and Ross 2000), it is also telling of the distinct boundaries between nursing and medicine that serve to inform her professional identity. For example, Karla's actions serve to inform the Registrar of the identity he should possess and how this should be practised. Karla's enforcement her own identity represents a distinguishing and separating of professional boundaries through assertion of notions of 'us and them' in a manner that defines the identity of oneself in contrast to the 'Other' (Jenkins 2000; 2014). In addition, the boundaries of the relationship between the two are defined by Karla's expectation that drug dosages should be decided and instructed by medical professionals, even if do CCNs possess such knowledge.

Karla does not have the authority or associated responsibility to undertake the task of calculating the prescribed dose of medication. These lie with the Registrar, and as such, it is he that is required to act, not Karla. Therefore, Karla's construction of her professional identity as a CCN is based on conflict of responsibility over scope of practice and her enforcement of these boundaries between herself and the doctor. The glare that accompanies Karla's refusal to share her knowledge upon the doctor's

request signifies a perception of the doctor's reliance on her performing activities and responsibilities that lie within his own scope of practice. The doctor's downward glance followed by his self-assertion that he will 'work it out' suggests he is acutely aware that it is his responsibility to calculate the required dose of medication for the patient. As such, this exchange reflects the doctor's is still learning, and avoids the responsibilities of his role, to exploit Karla's clinical knowledge base. This indicates that while CCNs' professional identity is based on their knowledge and ability to collaborate within the unit, it is also constructed on their ability to resist exploitation by other health professions (Carver 1998). This means that CCNs' professional identity is constructed through their assertion of inter-professional boundaries, but blurring these when necessary and appropriate.

## **Conclusion**

This chapter analysed how CCNs construct professional identity in inter-professional interactions. It argued participants draw on their shared knowledge base to construct their professional identities though negotiating jurisdictional boundaries in their interactions with other health workers. In doing so, it highlighted how CCNs' professional identities are confirmed and challenged through other health professional's inclusion or exclusion of nursing knowledges to the decision making process.

The examples presented demonstrate that interactional processes are contingent, as they are shaped by structural and organisational influences, including the seniority and gender of staff involved, the spatial and temporal dimensions in interactions occur, and dominance of the medical profession. Active collaboration was more likely between senior CCNs and the Consultant on the early shift, and CCNs and Registrars on the night shifts however, it also extends to CCNs' collaboration with junior doctors and Allied Health professionals on the early shift. Passive collaboration on the early and late shifts was characterised by doctor's need for, and the relevance of CCNs' knowledges.

The chapter showed how biomedical knowledge dominates the ICU and the different forms of collaboration are shaped by its priority. Yet, it also indicated the contextual valuing of CCNs' knowledges in inter-professional collaboration; while in some instances it was considered complementary to medical knowledge, in others it was disregarded. Moreover, the boundaries of professional knowledges and practice are not fixed rather, they become blurred and demarcated; while professional knowledge is shared, it is done so contingently in response to influences external to nursing.

Such contingency promotes a lack of clarity in CCNs' practice role by contributing to lack of definitive demarcation of the jurisdictional boundaries between health professions. This blurring of boundaries problematizes CCNs' constructions of difference and, this contributes to an ambiguity of professional identity. The significance of contextual constructions of difference points to possible negative implications for professional recognition, worker satisfaction and achievement of collective goals, and the consequences of these for on-going staff retention.

The organisational and structural influences of CCNs' practice are considered in the following chapter, 'CCNs Intra-professional Interactions', where spatiality, temporality, gender and organisational recognition all shape constructions of professional identity.

## CHAPTER SEVEN

# CCNs' Intra-professional Interactions

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### **Introduction**

The previous chapter showed how CCNs draw on their knowledges to negotiate jurisdictional boundaries during their interactions with other health professionals to construct professional identity. This chapter shifts analysis to CCNs' construction of professional identity within intra-professional interactions. I argue that these contribute to the ambiguity of professional identity as it is influenced by similar structural and organisational forces as inter-professional processes, such as tempo-spatial dimensions of practice and the dominance of medicine.

The chapter reveals that although CCNs share common ideas of specific temporal rhythms structuring their practice, temporality also forms a central point of difference in CCNs' professional identity processes. CCNs' construct differences in practice approaches across the temporal boundaries that separate the three nursing shifts, and this is suggestive of two different culture sharing groups of CCNs practising within the ICU.



This is significant as it highlights divergent perceptions of professional identity, but moreover, draws attention to a discrepancy between the autonomy that is promoted in nursing's construction of professional identity, and the collaborative practice that informs the identities of participants. These differences in practice include and exclude CCNs, and these processes contribute to tensions between them, which ultimately, negatively impact on group cohesion and on professional identity construction.

The chapter highlights the necessity of intra-collaboration and discusses four specific examples to demonstrate the contextual nature of collaboration, conflict and control: the preparation of medication; acute events within the unit; CCNs' meal breaks; and temporal boundary work. These epitomise power process of ownership and trade of resources that underpin collaboration, conflict and control between CCNs (Lingard et al. 2004; Nugus et al. 2010).

### **Preparation of medication**

As established in the previous chapter, CCN practice within the ICU is characterised by collaboration. This extends to intra- professional collaboration, which is necessary to completing of a variety of routine

nursing tasks within the ICU. Marcus explains this necessity for CCNs to collaborate:

*It's never a one man [sic] show, you can't do everything; I can't do everything myself... Even doing a procedure, or assessment, or giving drugs; everything is a co-operative work...it's always teamwork (Marcus).*

Marcus' identification of 'giving drugs' as a task that requires collaboration between CCNs corresponds to legislation set down in Tasmanian Poisons Regulations (2008). This stipulates that drugs of a specific classification or 'Schedule' require checking by two individuals licensed to do so. In the case of the ICU, doctors and Registered nurses hold such licences and, as such, administration of drugs requires inter-professional collaboration between one doctor and one Registered Nurse, or intra-professional collaboration between two doctors or two Registered Nurses. Since CCNs are the most readily available staff members within the ICU who have the jurisdiction to deliver medication, they typically check and sign drug charts to indicate medication is correctly prepared and given. The large amount of medication being delivered to patients within the ICU means that 'checks' are a frequent feature of everyday nursing practice. The following examples show how while 'checks' take different forms, they demonstrate similar elements:

*An unidentified CCN carrying a calculator and drug chart approaches Airlee and asks, 'can I get a check?' Airlee looks to her and the CCN holds up the calculator and form to Airlee's eye line and begins pushing the buttons on the calculator while she calls the steps of a mathematical equation. She*

*finishes 'so that's 6micros/ml? Airlee peers at the figure displayed on the calculator and says, 'that's right'. The unidentified CCN moves away (CCNA602).*

*A CCN approaches Donna and asks, 'can I get a check?' The CCN holds the patient's drug chart and a small plastic IV flask resting on its top. Donna turns to look at the CCN standing next to her. The CCN tilts the drug chart towards Donna and points to it as she reads out the order. Donna nods and repeats the order as she looks to where the CCN is pointing on the document. The CCN shows Donna the IV flask and Donna looks at it before looking at the CCN with a confused look on her face. Donna asks, 'where's the drug?' A blank look crosses the CCN's face and Donna laughs as she says, 'you forgot the drug!' The CCN blushes and laughs and scurries off in the direction of the drug cupboard with her head hung low; she returns moments later and opens her hand to Donna and shows her two vials in her open palm. Donna smiles and nods to her as she signs the drug chart (CCND1006).*

*Brenda and Indiana stand at the drug cupboard with Brenda's patient's drug chart open. Indiana pulls out a vial from the cupboard, shows it to Brenda and says, '1 gram'. Brenda looks at the vial and then down at the drug chart before she nods and repeats, '1 gram'. Brenda begins to draw up the drug before she leaves suddenly to attend to her patient ...Indiana finishes the task and carries the IV bag, additive label and drug chart over to Brenda who signs the label and the drug chart (CCNB1604).*

These exchanges demonstrate a number of elements that characterise the activity of 'checks' within CCN practice. This includes the sighting of the drug order in the patient's drug chart; confirmation of correct drug dosage; and, with the exemption of the first passage, the signing of a medication order. These actions accord to the requirements of Tasmanian Poisons Regulations (2008) and this indicates the importance of nursing's legal framework within CCN practice. These interactions additionally indicate the salience of intra-professional collaboration as necessary to adhere to legal frameworks. The CCNs' actions underscore an 'interdependency'

(D'Amour et al. 2005: 116) that is necessary to the completion of their shared goal, specifically the preparation of medication within the required legal specifications. Such reliance is comparative to participants' perceptions of inter-professional collaboration (discussed in the previous chapter), as the CCNs act as equal partners in the sharing of knowledge and time, that are characteristic of collaborative endeavours (D'Amour et al. 2005; Kraus 1980; Lingard et al. 2004).

While the collaborative efforts of Brenda and Indiana can be seen as necessary to the legal requirements of their practice, their interaction is also revealing of their ability to negotiate the legislative and organisational protocols and procedures that underpin the social order and demands of the ICU. In Brenda leaving Indiana to attend to another task, and Indiana completing the task alone, the two CCNs negotiate the established protocol of drug delivery, and thus the social order of the ICU, to achieve specific aims, namely the checking of medication in the most efficient manner (Strauss et al. 1978; 1963), despite unforeseen interruptions. As such, their actions align with the emphasis on efficiency within the contemporary health policy as informing their practice (Duffield, Gardner and Catling-Paull 2008; Kirpal 2004a; Sanders and Harrison 2008).

While an emphasis on efficiency can promote collaboration between CCNs, this can be inhibited by the spatial arrangements of the ICU. This can give rise to tensions between CCNs. Brenda acknowledges:

*As the In-Charge I've seen it...if you're in a room which isn't close to anyone; you're quite isolated. But you're restricted as well because you can't get things yourself so...[it's] not that you want to be totally isolated and independent, you're just where your position is in the room is why you are'* (Brenda).

This demonstrates how the spatial arrangements of the unit mean that CCNs allocated to specific bedspaces can become 'isolated' and 'restricted'. In Brenda saying 'not that you want to be totally isolated', she implies that intra-professional collaboration, rather than autonomy, is the preferred practice approach within the unit. In addition, her explanation of 'it's just your position' denotes that spatiality is a central consideration in intra-professional collaboration.

The influence of spatiality on intra-professional collaboration is most evident in observations of CCNs allocated to rooms that are deemed "dirty". A dirty room refers to a room in which a patient diagnosed with an infectious condition, such as MRSA (Methicillin-resistant

Staphylococcus Aureus), and is nursed in isolation from other patients.

Gaynor describes her actions as she nurses an infectious patient in an early shift:

*Gaynor stands inside the threshold of room 3 where she is nursing an infectious patient. Her face is flushed... she removes her yellow paper gown and gloves and disposes...them into the infectious garbage bin. She steps out of the room... waves one hand in front of her face... and exhales loudly, 'I thought I was never coming out of there'. The float approaches carrying an IV flask... which she hands to Gaynor.... Gaynor looks to her nursing student and points to the IV flask as she tells her, 'you can go back in and get this going; I've been in there all morning' (CCNG2010a).*

Gaynor demonstrates the universal precautions associated with nursing an infectious patient. While inside the room she wears the required protective attire of 'yellow paper gown and gloves', which she disposes of as she leaves the room. In commenting, 'I thought I was never coming out of there' and 'I've been in there all morning', Gaynor communicates how her movement around the unit has been restricted through her allocation to this specific space within the unit. Gaynor's experience aligns with Brenda's previous statement that spatiality can reduce contact between CCNs, and can cause isolation temporally. This reduced contact influences intra-collaborative processes and the performance of particular activities that inform professional identity (Allen 2002; Seneviratne, Mather and Then 2009).

The spatial arrangements of the ICU, and the valuing of efficiency within, can intersect with participants' negotiation of its social order to cause tensions between CCNs. The next excerpt details a Float CCN's negotiation of the regulations of medication preparation in response to the spatial limitations of Gaynor's nursing of a dirty patient:

*The Float CCN leaves an IV bag and additive label on the overbed table. She tells Gaynor, 'sign your life away', as she walks away. Gaynor reaches to sign the label; she stops and pulls a face as she looks at the patient's surname on his chart and looks back to the IV label. She calls to the Float...the Float comes over and Gaynor points to the surname on the sticker and gives her a hard stare, 'this is for this man?' The Float looks at the sticker, 'yes'. Gaynor holds up the notes ... The Float stares blankly; Gaynor says 'wrong surname'. The Float says, 'oh shit... sorry; it is for your man; sorry what's his name'. Gaynor replies, 'Mr. [patient's surname]'. The Float explains, 'yes I've signed for it in the drug chart; I've just written the wrong name'. She walks away as she gives Gaynor a dismissive wave. Gaynor glares harder... crosses off the incorrect surname, prints in the correct one and initials next to it...she shakes her head and screws up her face. She says under her breath, 'yeah sign my life away indeed' (CCNG2010).*

In this scenario, the Float CCN prepares the medication away from the direct sight of Gaynor, who is the CCN administering the medication. This occurs because Gaynor is confined within the dirty room to which she has been allocated. In not having Gaynor witness the process, the Float risks making a critical practice error that impacts not on herself, but on Gaynor, who holds ultimate responsibility for the drug's correct delivery. The Float's delivery of the IV bag to Gaynor with the direction to 'sign her life away' represents two things; the documentation of the two CCNs witnessing the medication's preparation as set down in legal requirements

and, the transfer of responsibility between them. Gaynor demonstrates responsibility in her practice through checking the label, and her subsequent identification and management of the Float CCN's error.

This interaction exposes tensions between responsibility and accountability that inform Gaynor's practice on the one hand, and the Float CCN's offhandedness on the other. While the passage does not fully capture the sarcasm in Gaynor's verbal expression ('yeah right'), her non-verbal gestures (glaring, shaking of head, and screwing of face) suggest her disapproval of the Float CCN's flippant actions. These include the Float's humorous request to 'sign your life away', her failure to recognise her own mistake (her blank look), and her inability to articulate the patient's surname despite insisting 'it's for your man'. Furthermore, the inclusion of the word 'just' in her explanation 'written the wrong name', implies an underplaying of the seriousness of her oversight. In light of the exchange between the two CCNs, Gaynor's disapproval denotes a perceived difference between her own sense of, and the Float CCN's lack of, responsibility and accountability. This is telling of the significance of these elements as informing Gaynor's professional identity.



## Acute events

The second example of intra-professional collaboration, conflict and control that inform CCNs' professional identities are those of acute patient events within the unit. The following fieldnote extract describes an event involving Indiana performing the role of CCNIC, and another CCN, in the early morning hours of a night shift:

*The CCN allocated to bed 7 calls to Indiana, 'is the doctor around?' Indiana replies, 'he's in the tute [tutorial] room [sleeping]; Why?' The CCN breathlessly tells Indiana 'my patient is breathing too fast'...Indiana approaches the bed, puts her hand on the back of the patient's neck and looks between his chest and the clock...Indiana says, '21 reps [respirations per minute] and the CCN nods. Indiana speaks gently but forcefully to the patient, 'you need to calm down a little bit; now I want you to just think about taking nice big deep slow breaths; that's it'...She places an oxygen mask over his face and says, 'let's see what his sats [oxygen saturation levels] are now the mask is back on'. Indiana adds, '99 [per cent oxygen saturation], okay' (CCN12612).*

In this interaction, an unidentified CCN indicates her concern to Indiana with the words 'is the doctor around?' While Indiana supplies the information the CCN requests ('he's in the tut room'), she goes a step further to inquire on the reasoning behind the CCN's appeal to the doctor ('why?'). When the CCN articulates that her patient is 'breathing too fast', Indiana assesses the patient ('21 resps'[iration]s), and takes the necessary interventions (instructing the patient and applying the oxygen mask) to successfully manage the situation ('99 okay').

Indiana's actions reflect her engaging in collaborative decision-making with the CCN at an intra-professional level. She trades her ownership of the resources of knowledge, skills, time, as well as the patient and the bedspace with another CCN in a power-sharing process (Lingard et al. 2004; Rose 2011). The statement 'he's in the tute room' has dual meanings between the two CCNs. While it explicitly refers to the doctor's location, it is an often heard phrase between CCNs on the night shift that implicitly refers to the area where the night shift Registrar will catch a couple of hours sleep (patients' conditions permitting). In Indiana not wanting to disturb the doctor, her intra-professional collaboration with the other CCN can be observed as a necessity, yet her decision denotes her capability of knowledge and clinical skills, and a willingness to share these resources at the intra-professional level (Nugus et al. 2010).

While the sharing of knowledge and clinical skills between CCNs is not uncommon within the unit, these processes do not always entail collaboration. Some interactions between CCNs exhibit signs of overt conflict, as witnessed in an exchange between Catrina (taking the role of Float CCN), and an unidentified CCN on an early shift:

*Catrina sits in the OA when an alarm begins ringing in room 4. She... looks... and sees the monitor flashing through the window. She sighs heavily, shakes her head and hurries over. She...stands beside the blue lipped, breathless*

*patient who is wearing an oxygen mask...and looks to the oxygen flow valve on the wall...She shakes her head and instructs the patient to 'take a couple of deep breaths for me'... as she reaches across to turn the oxygen valve... Catrina sees the CCN allocated to the room outside and calls to her, (first name) 'did you change the flow of oxygen?' The CCN replies 'yes'. Catrina's voice rises 'well her sats [oxygen saturation] level just dropped to 94!' The CCN shrugs, 'I thought that the [O2 saturation] meter was wrong'. Catrina's jaw drops, 'what?' She marches over to the seated CCN and sighs heavily as she places her hands on her hips and leans over her, 'that's not a good way to think, especially since you turned her oxygen down' (CCNC908).*

Catrina and the CCN's interaction oppose that of the collaborative efforts between Indiana and the same CCN earlier. While Catrina and Indiana provide support, they do it in different ways. Indiana's represents the trade and ownership of resources that are features of the power sharing processes underpinning collaboration (Lingard et al. 2004; Rose 2011), Catrina's attending to the patient in response to the alarming monitor in the CCN's momentary absence reflects a different dynamic. Catrina's non-verbal gestures (sighing and shaking of head) indicate a sense of disapproval towards the situation generally, and the actions of the CCN more specifically. These actions, as well as her vocal challenge of the CCN's practice ('did you change the flow of oxygen?'), highlight a power differentiation between the two CCNs based on Catrina's perceived sense of her superior knowledge and skills (Barth 1969; Jenkins 2000; 2014). The political dynamics of the exchange are evident in Catrina's unrequested attendance to the patient and aggressive posture (placing hands on hips and leaning over the CCN), when addressing the CCN. These reflect not a

process of equal trade and exchange of resources, but one of her commandeering the resources of space and power over the patient. This suggests that autonomy, rather than collaboration, informs Catrina's approach to practice and professional identity, at least in this instance. Finally, the fieldwork notes reveal that in situation where a patient is not receiving optimal care, this is managed by CCNs' negative sanctioning. Consequently, conflict replaces collaboration in informing professional identity.

### **Meal breaks**

The third example in which intra-professional processes of collaboration, conflict and control inform CCNs' professional identities manifest is that of meal breaks. Meal breaks are divided into three separate temporal dimensions, referred to as early, second and late. These symbolise intra-professional collaboration, as CCNs allocated to each meal break are tied together as each break is dependent on CCN coverage (Durkheim 1933; Zerubavel 1979b).

CCNs' meal breaks are also representative of a fine grain temporal rhythm that structures the large scale temporal rhythm of their working shifts (as discussed in the previous chapter). Brenda's co-ordination of meal breaks as she performs the role of CCNIC during a late shift are described in the following excerpt from fieldnotes:

*Brenda tells Donna, 'I've organised tea breaks between you and the CCNs working in rooms 2 and 6'. Donna nods. Brenda explains, '[CCN working in room 2 first name] can go at ten to, [CCN in 6 first name] can go at quarter past and you can go at half past; is that alright?' (CCNB2704).*

This illustrates CCNs' relations of interdependence during the particular fine grain temporal rhythm of meal breaks. That is, a CCN's attendance to an early break influences the practice of CCNs on the second and late meal breaks. Brenda has co-ordinated meal breaks between three CCNs ('you and the CCNs...in rooms 2 and 6'). This means that when the CCN allocated to Room 2 goes to her break 'at ten to', Donna and the CCN working in Room 6 must nurse two patients between them rather than one each. In addition, when the CCN in Room 6 leaves at 'a quarter past', Donna is required to nurse all three patients until the CCN allocated to Room two returns from her thirty minute break at 6.25pm. The influence of CCNs' interdependency during meal breaks is illustrated by Brenda on an early shift:

*Brenda is cleaning her patient's CV (Central venous) line when the MO arrives at the end of the bed... The doctor asks 'are you going already [with the treatment]?' Brenda shakes her head and sighs, 'we haven't started the*

*machine yet...we've had a bit of a problem with staff this morning'. The CCN at bed 8 looks over and calls to Brenda, 'don't you think you should wait? It's a two person job; you need someone to feed you what you need'. Brenda replies, 'I'm just doing this bit. I was gonna call if I needed anything'. The CCN asks 'but what about if no-one can come when you need them?' She nods to the new admission being wheeled in and suggests, 'wait until Edwin gets back [from lunch]'. When did he go?' asks Brenda. The CCN tells her, 'about 10 past' Brenda looks at the clock reading 12.30pm, 'not long now then'... she changes her gloves and moves over to bed 11 to help transfer the new admission (CCNB1101).*

Brenda's explanation 'we haven't started...yet' is indicative that the task is running behind time. She couples this with shaking her head and sighing, which is evocative of her frustration at the situation.

Yet it is difficult to determine if this is directed at the doctor's questioning of the delay, the 'problem with staff this morning', or the delay itself. What is most telling, however, is the temporally based constraints on collaboration that have influenced this delay and the difficulties this presents for Brenda. Brenda's inability to collaborate due to staff shortages aligns with the CCN's claim 'it's a two person job' and her question, 'what if no one can come?' The CCN's further inquiring of 'don't you should you should wait?' and 'wait until Edwin gets back' indicate the influence of fine grain temporal rhythms in constraining particular nursing activities. Thus meal breaks, while necessary, can impede CCNs' role performance as they compromise the ability of CCNs to be intra- professionally collaborative.

Brenda's actions are revealing of particular values embedded in the CCN practice that inform her professional identity. Her undertaking 'this bit' of a 'two person job' with the plan to call for assistance if necessary, hints at her eagerness and impatience to begin the procedure. This is suggestive of the time constraints within nursing practice, and is demonstrative of CCNs' engagement in time management strategies ('just doing this bit') to negotiate time limitations within their practice as well as those imposed organisationally (Bowers, Laurant and Jacobson 2001; Fine 1990; Fine 1996; Waterworth 2003).

Brenda's decision to move from a task that she is unable to complete to assist with a more pressing task signifies the value attached to successful time-management strategies within her practice and professional identity. Such values are supported by Marcus and Penny when they describe the ideal type of a CCN:

*Prioritising things and doing things in an order... Prioritising things and doing things according to the priorities is the important thing (Marcus).*

*Hard working, good time management...to be able to critically think about things...good communication,...time management; I think that's about it (Penny).*

The value that Penny and Marcus place on 'time management' and 'prioritising' is demonstrated in the repetition of these words in their interview quotes. Moreover, Penny identifies four qualities that she perceives as important, of these 'time management' is the only one repeated. The significance of CCNs' time management in the context of intra-professional collaboration is marked when tensions arise from the intersection of particular temporal structures. This is specifically the case when the different large scale rhythms of medicine and nursing's shifts, and the fine grain rhythms that constitute them, are not temporally aligned. While strategies to overcome this tension are alluded to in the earlier example of Brenda's time management, Gaynor uses an alternative strategy during one early shift:

*Gaynor explains 'my patient is having a trachy [tracheostomy] today'. She adds, 'at 12midday'... She rolls her eyes, 'yeah great time; right on lunch. It means it has been one big rush all morning'... She shakes her head, 'I don't know why anyone would think 12 o clock is an appropriate time to do it; I don't know how we are going to work out relief for lunch breaks'. She shrugs her shoulders, 'I probably won't get one [lunch break]' (CCNG1505).*

Gaynor voices how the '12 midday' timing of her patient's 'trachy' has structured her work activities in such a way that 'it has been one big rush all morning'. Furthermore, the scheduled timing of the procedure 'right on lunch' will make 'relief for lunch breaks' challenging, to the degree that she 'probably won't get one'. Gaynor's response to the situation is imparted in three ways: her sarcastic tone when she suggests, 'yeah great



time'; her accompanying body language of eye rolling and head shaking; and her statement 'I don't know why anybody would think 12 o'clock is ...appropriate'.

This example highlights the temporal flows of meal breaks can be disrupted by external sources, which also impact on the work activities of CCNs. The tension arises from an incompatibility between the temporally structured routines of medical staff and nursing staff (Zerubavel 1979a).

While it is the medical staff that have decided on the timing of the procedure, their dominance within the hospital hierarchy (Freidson 1970a; 1970b; Willis 1989; 1994) means that nursing staff must regularly accommodate doctors' routines into their practice, including when certain activities are performed. It should be said that while it may seem that Gaynor's experience applies to only inter-professional collaboration between doctors and nurses it extends to the intra-professional level. This relates to activities that require more than one CCN, and the occurrence of their meal breaks. Significantly CCNs are required to collaborate with one another to ensure the availability of nursing staff at times specified by doctors (and to a lesser degree, Allied health professionals).

The incompatibility between the temporal structure of doctors and CCNs' work is visible in Gaynor's disapproval of the timing of the procedure through both her verbal (sarcasm) and non-verbal (rolling of eyes and shaking of head) gestures. Her disapproval can be seen as a negative response to the disruption of the timing, tempo and sequence of the activities of her practice. Gaynor's negative responses can be attributed the doctors' decision-making on timing contributing to her experiencing time as 'unpleasant or dysfunctional', as she has 'too little time' (Fine 1990:96) to complete the activities of the early nursing shift as required. This represents an external restriction on Gaynor's utilisation of time, which is theorised to decrease worker dissatisfaction (Strauss et al. 1963;1978; Fine 1990; 1996). Gaynor's compromise of missing her break, evident in her claim of 'I probably won't get one', is accompanied by non-verbal expressions of disapproval, and reflects a sense of dissatisfaction that Sharbaugh (2009) argues reduces the perceived strength of an individual's professional identity.

In expressing her disapproval, Gaynor conveys the highlighting of difference that is characteristic of identity processes (Jenkins 2000; 2014). In referencing 'I don't know why anybody would think 12 o'clock is an appropriate time', she constructs herself and the other CCNs ('we') in

opposition to others whose work is organised around different temporal structure. This is suggestive of CCNs' professional identities being informed by a culture sharing group that attach common meanings to time within their practice that distinguishes them from the temporal rhythms and identities of other health professionals in the ICU.

The CCNs' common understanding of time demonstrated in the examples of taking and relieving for meal breaks. CCNs, including Catrina, Fern and the CCNIC (CCN In-Charge), convey this commonality:

*Catrina and Fern sit casually chatting among a group of CCNs, including the CCNIC in the Observation Area. Catrina glances at the clock and around the unit 'does anyone needs a drink?' The CCNIC replies 'almost everyone's been'. Fern looks at the clock... and sighs loudly, 'I can't believe it's only 10 'o clock'. The others agree, 'I know', 'yeah yawn'. An unidentified CCN interrupts the conversation, 'I'm going to have my break now', and gives handover to Catrina. The CCNIC dismisses the CCN with a wave of her hand; as she leaves the CCNIC calls 'take your time'. The CCN replies 'I'll only be 15 minutes', but the CCNIC insists, 'no don't hurry back; things are quiet'. Catrina agrees 'yeah take your time' before adding in a low voice from the side of her mouth, 'just don't take longer than 15 minutes'. All the CCNs laugh loudly (CCNC0909).*

In this excerpt, CCNs experience a 'quiet' time in the shift. This is evident in the CCN In-Charge's ('things are quiet'), Fern's ('I can't believe it's only 10 o'clock) and the other CCNs' (yawn and sighs), acknowledgment of the slow passage of time. The In-Charge draws on the lull in activity to suggest the CCN to extend her tea break ('take your time' and 'don't hurry back'). Despite this offer, the CCN asserts that she will 'only be 15

minutes'. While Catrina lends overt support to the idea of an extended tea break ('yeah take your time'), the latter part of her comment ('just don't take longer than 15 minutes'), is contradictory to the first, signifying her sarcasm.

The above interaction indicates the contingency and negotiability of some finer grained temporal rhythms that structure and constrain CCN practice. In contrast to Gaynor's earlier negotiation of dysfunction arising from the temporal constraints of the medical practitioners, the CCNs negotiate dysfunction in terms of 'having too much time' (Fine 1990; Fine 1996). While Gaynor's negotiation of time limitations involves an adverse compromise ('I probably won't get one'), this interaction shows there are occasions when CCNs have a longer break time (Fine 1990). What is more notable is the CCN's articulation of her choice to 'only be 15 minutes', Catrina's sarcastic comment, and the CCNs' laughter in response to Catrina, all of which are indicative of a shared non-negotiability of the temporal lengths of meal breaks.

The shared meanings of the non-negotiability of meal breaks are highlighted when these norms are perceived to be breached. This is

exemplified by an interaction Catrina and Brenda (who is performing the CCN-In Charge role for the late shift):

*Brenda moves about the Observation Area as she attends to paperwork and answers telephones. Catrina strides in and calls loudly, 'excuse me'. Brenda turns to face her and Catrina continues, 'I'm sorry but I have been waiting for 45 minutes'. Brenda asks, 'what?' Catrina answers, 'I am relieving at bed 9 and someone has been gone for 45 minutes'. Brenda...asks, 'who?' Catrina says, '(CCN's name)'...Brenda quickly...pushes herself from her chair as she says, 'I'll go and get her' (CCNB604).*

Catrina reports to the CCNIC Brenda that she has 'been waiting forty five minutes'. While she emphasises her point through reiteration within the phrase 'someone has been gone 45 minutes', she does not explicitly refer to meal breaks as the subject of her concern. Brenda quickly responds to 'go and get her' and moves towards the tea room once she establishes the CCN's identity. This signifies a common cultural understanding between the two CCNs in relation to the temporal structure of practice and its influence on intra-professional collaboration. Thus, Catrina's actions, as well as Brenda's response, signify a tension between CCNs' shared understanding of the strict thirty minute temporal structure of CCNs' meal breaks, and the extended period that the other has been away.

The CCN's delayed return can be seen to not only break the normative expectations associated with CCNs' meal breaks, but also a disruption to

the strictly structured fine grain temporal rhythm of meal breaks (Fine 1990; 1996; Reddy, Dourish and Pratt 2006). Due to the organic relationship (Zerubavel 1979a) that binds the two CCNs across meal breaks, the CCN's tardy return means that Catrina's own meal break has been delayed. The CCN's actions have placed an external constraint on Catrina's utilisation of her private time, in a manner similar to that of Gaynor's earlier noted compromise.

### **Temporal boundary work**

Temporality is a central element that informs participants' professional identities. While the early and late shifts are identified as sharing commonalities, CCNs distinguish these from the night shift. This is the case with Indiana, who works permanent night shift:

*People during the day...have stronger personalities which can mean that you're on your own, even though there are heaps of people around. Night shift's not like that; there's a lot of teamwork (Indiana).*

Brenda, who works night shift periodically as required by her monthly rota also demarcates between the early and night shifts when she says:

*I... like nights... because there's less senior people [rostered] on. And then you get more of an opportunity to do more acute things (Brenda).*

Indiana and Brenda indicate an autonomous approach to practice that is prioritised on the early shift. Indiana's reference to being 'on your own'

despite 'heaps of people being round', acts to convey practitioners' self-interest in the achievement of their own work activities to the exclusion of others. This is further strengthened through her contrast to the 'teamwork' approach of the night shift. Brenda's claim that 'less senior people on', which enables opportunities to undertake tasks of a 'more acute' nature, implies that Grade 4 CCNs outside the night shift implicitly or explicitly engage in exclusionary practices to promote their autonomy over patients at the intra-professional level, and thus marginalise the less, and moderately experienced CCNs. This is also expressed by Karla, as she explains her preference for night shift in hushed tones as she moves around a bedspace: 'There's a group of older staff here; like a clique... they mainly work during the day as that's where they can show off how special they think they are' (CCNK1906).

Karla's perception of the presence of 'a clique [of] older staff' who wish to 'show off', offers support to Brenda's earlier perception of 'less senior staff' being rostered on nights as providing greater opportunities to engage in 'acute things'. The presence of a clique of which whose members embrace autonomy over collaborative practice is also noted by Nina and Penny:

*Some nurses are very independent; they want to do things their way... and they don't work as well as part of a team. Whereas other people really embrace the teamwork; I'm one of those people (Nina).*

*Between the nurses I think there is [collaboration]... sometimes between the more senior nurses to the junior nurses, sometimes there isn't' (Penny).*

While Nina does not specifically refer to 'older' or 'senior' CCNs explicitly, her reference to 'some nurses' who are 'very independent' in wanting 'to do things their way', denotes the existence of a distinct group of CCNs within the unit that she demarcates as different. In emphasising that 'they don't work as well as part of a team' and contrasting this with 'other people' who 'embrace teamwork', Nina draws on the specific language of 'they', 'other' and 'I'm' to represent a process of inclusion and exclusion (Barth 1969; Fournier 2000; Norris 2001). This serves to construct her professional identity as informed by her belonging to a particular social group in opposition to the 'Other' (Jenkins 2014). In this case, Nina identifies as being a part of an intra-professional collaborative team that stands in contrast to those who do not construct their professional identity in this way, and this corresponds to the earlier quotes of Indiana and Brenda, who perceive this group as a distinctive feature of the early shift.

The different attitudes towards collaboration by the two temporally bound groups of CCNs, can be understood through Nugus et al.'s (2010:899) concepts of 'collaborative power' and 'competitive power'. Participants



construct their identity by distinguishing themselves from a specific group of CCNs on the basis of their exercise of power. This is achieved through drawing on a discourse of collaboration, exemplified in both Indiana and Nina's utilisation of the word 'teamwork', which is associated with collaborative power (Kraus 1980; Nugus et al. 2010). The two CCNs accentuate their differences from the 'other' by stating, 'very independent... 'their way' (Nina), and 'show off how special they think they are' (Karla). This lexicon is aligned with the zero-sum domination associated with competitive power, as there is a limited amount (Kraus 1980; Nugus et al. 2010; Weber, Gerth and Mills 1946), and is suggestive of the other CCNs' exercise of autonomous power.

The lack of clarity of professional identity, and the group dynamics that contribute to it, are also expressed through the power dynamics between the two groups based on temporal difference. An example is the way night shift CCNs prioritise the politics of the early shifts as central reasons for their choices of permanent positions on night shift. Indiana, for example, explains her shift preferences while sitting in the Observation Area: 'I work permanent night shift. I don't like working days; working nights provides an opportunity to get away from politics' (CCNI1804).

The political nature of early shift is also identified by CCNs who rotate through the night shift as required, including Catrina: 'So night times are good to get away from the riff-raff, you know the politics' (Catrina). In explicitly citing 'politics' as associated with the early shift, Indiana and Catrina allude to the two groups of CCNs that characterise the power dynamics between the temporality of shifts. This can be understood as one group's control of resources at the expense of the other within everyday practice (Weber, Gerth and Mills 1946). An example of one such resource is the allocation of the supernumerary roles of CCN In-Charge, Access CCN, and Float (detailed on page 100 of Chapter Three), as Catrina explains:

<i>Catrina:</i>	<i>There's only two roles; I'm on the floor or Access. That's the only two roles I'm allowed to do. I like the Access only 'cause I like going to like the MET calls or CODE BLUES or something like that, but I'd rather be hands on...</i>
<i>MJB:</i>	<i>Do you not do the In-charge because you are not senior enough?</i>
<i>Catrina:</i>	<i>Yeah... or the politics of the unit; you know, you're not old enough, or you're not given a chance.</i>

Catrina's perception of the controlling of supernumerary roles by particular CCNs is also expressed by Brenda, as she talks about her role preferences:

*I don't like doing all clinical; five days straight. If I work five days straight, I like to work three clinical, one In-Charge and an Access role, so we help everybody... So the Access role's good, the In-charge role's good, clinical is good, probably two or three in a row and then a break; not all the time.*

*That's why it's shared; even though some people appear to be doing it more than others (Brenda).*

The controlling of supernumerary roles by specific individuals on day shift is evident in staff allocation as the following excerpt from my field notes describes:

*Indiana opens the allocation folder and asks, 'who wants what?' The CCNs reply in turn, 'can I have 2 and 3? I was there yesterday', '10; I was there last night', '11 for me please if you can?', '4 and 5 would be good if you can manage it?' Indiana writes in each allocation as she confirms it with a nod and a 'yes'. A CCN says, 'I put myself in for IC'...Indiana nods and looks at the allocation sheet and says, 'oh you've already written it in' (CCN12616).*

The control over resources is further evidenced in instances when CCNs holding supernumerary roles assume management of a patient that is allocated to a CCN performing a clinical patient load role. For example:

*The Registrar tells the CCN at bed 9 that her patient can be extubated. The CCNIC (CCN In-Charge) immediately comes over and sends the CCN allocated to the patient to her tea break... As soon as the CCN turns the corner the CCNIC calls to the float...'can you give me a hand to extubate this patient?' Donna and two CCN working nearby all stop working and quickly look to the CCNIC and the float. The CCNIC says to the float 'let's get this done quick'...Donna and the other CCNs all shake their heads. Moments later Donna is at the rear of the unit when the CCN allocated to bed 9 passes by and says, 'I'll go extubate this patient now'... Donna replies softly, 'um I think you'll find your patient is already extubated'. The CCN's eyes widen. She snaps, 'what?' Donna looks to the ground as she answers '(CCNIC's first name) has already done it'. The CCN... says in an irritated tone, 'she'd better not have...she didn't waste any time did she?' The CCN turns quickly and marches up the corridor... Donna explains, 'I can understand why (CCNs first name) would be upset; I mean it is her patient (CCND3014).*

In the interaction above, the CCN In-Charge exercises power over the unidentified CCN through the former's maximisation and utilisation of

resources at the latter's expense. In the CCNIC sending the CCN to 'her tea break', the CCNIC effectively extends her own control over professional identity construction within collaborative practice. These resources include not only the knowledge and skills necessary to undertake the clinical task of extubation, but also access to the patient's body and the area of the bedspace (Lingard et al. 2004; Rose 2011). While the CCNIC asking the float CCN 'for a hand to extubate this patient' and stating 'let's get this done quickly then' represents collaborative power between them, it additionally shows the exercise of competitive power. This is because the CCNIC takes control of the resources allocated to another CCN without exchanging respect for the latter's authority.

The CCNs respond to the CCNIC usurping through non-verbal (shaking of heads and widening of eyes) and verbal ('she better not have') communication, which are exhibited by the CCN allocated to the patient and other CCNs. As the perception of the CCNs are shared, this suggests their belonging to a culture sharing group separate to that of the CCNIC and Float CCN (Jenkins 2014). Furthermore, the tension between the CCNs, the CCNIC and Float CCN are seen to arise from the CCNIC's breach of normative practice expectations within the ICU, as the latter two disempower the allocated CCN by taking control of her professional activities (Spence Laschinger, Wong and Greco 2006). This corresponds not

only to participants' claims of the presence of a distinct group of CCNs on the early shift, but also this group's influence on power dynamics within this temporal dimension as their tendency for autonomous practice disempowers, rather than empowers, staff.

The differences in the power dynamics between the early and the night shift are further highlighted when informants explain their preferences for night shift. For example, night shift Karla expresses the differences in terms of individual personalities: 'I work pretty much permanent night shift...I do it to avoid the stronger personalities that work during the day', as she pulls a distasteful face (CCNK 1906).

Karla indicates her aversion to the 'stronger personalities' on the early shift verbally and emphasises this with a look of distaste. Her non-verbal communication is just as significant, if not more so, than her verbal articulation (Goffman 1959). These outward expressions serve to designate her negative attitude towards a group of particular personalities on the early shift. Karla's reference to the 'stronger personalities' on 'the day' shift resonates with Indiana's claim of the 'politics' of the early shift. As such, both CCNs denote political forces at play, as the words 'stronger' and 'politics' allude to domination and oppression that underpin competitive power (Nugus et al. 2010; Weber, Gerth and Mills 1946). These CCNs'

explanations for preferring night shift separates them from the political nature of the early shift, and thus they construct their professional identity in contrast to staff from the early shift by engaging in the processes of difference characteristic of boundary work to distinguish themselves (Barth 1969) from the power dynamics early shift. Therefore, Karla and Indiana convey a shared cultural identity based on the large scale temporal rhythm of the night shift (Jenkins 2014).

Ironically, non-permanent night shift participants such as Brenda, not only laud it for the opportunity to engage in acute clinical practice, but also discuss it with reference to individual personalities:

*Brenda stops and says 'hello' to me. She has just finished a rotation on nights and I ask her how she feels, 'oh much better!' She rolls her eyes skyward as she says in a low voice, 'sometimes there's personality problems that you just can't avoid you know'. She...adds in a loud voice and laughs, 'everyone is better on days' (CCNB2702).*

Here Brenda engages in a similar process of difference to Indiana and Karla, however, as a non-permanent member of night staff, she is the outsider. Therefore, her construction of difference, while emphasising 'personality problems', refers to the night, rather than the day shift staff, indicating that she is excluded by them.

Another way exclusion is achieved is by specific boundary work performance termed 'atrocities stories' (Allen 2001; Dingwall 1976; 2008; Turner 1986). Atrocities stories are narratives that constitute boundary work processes at the micro level, particularly those between health professions (Dingwall 1976; 1977; 2008; Turner 1986). These narratives generally focus on one profession's practice reporting another's in an inferiorising manner, with demarcating professional boundaries between them. This confirms professional identity through stressing the normative expectations of each group (Dingwall 1976; 1977; 2008). While atrocities stories are well acknowledged elements of intra-professional processes of difference between management and clinical areas of nursing (Allen 2000; 2001), participants' performances are more nuanced as they focus on the differences between the temporal dimensions of each nursing shift. Therefore, temporal dimensions perform a significant role in professional identity construction.

CCNs' references to the autonomy can be seen as examples of atrocities stories, as their narratives serve to acknowledge the temporal boundaries of difference across which professional identity is constructed (Dingwall 1976; 1977; 2008; Timmons and East 2011; Turner 1986). This acknowledgement of difference constructs them as a subculture, or a

particular 'segment' (Bucher and Strauss 1961) of CCNs within the ICU by separating themselves from the promotion of autonomy by a temporal based group of CCNs on the early shift. The practice distinction of CCNs is representative of deprofessionalisation, as differentiation involves discourses that serve to discredit the knowledge and practices of particular CCNs, and compromise the professional identity of practitioners (Dingwall 2008). For example, the boundary work of night shift CCNs such as Indiana, focus on atrocity stories that discredit the actions of a particular group of CCNs on other shifts. The following interview extracts demonstrate how Indiana draws on the act of bullying during the late-to-night shift changeover to convey tension with other shifts, thus, she exemplifies the telling of atrocity stories:

*We have such a culture of bullying... every time I started a night shift I'd be met by tears; people would be angry and in tears- every single time (Indiana).*

*We have a culture of bullying... I watch a certain group of people who are on [the early shift]. One of them will go and get handover in bed 7; the others would go there as well. I just feel sick for the person that's handing over because you just know they're all just standing there looking down on them; saying, 'oh well did you do this? Did you do that'? Did you do this?' Like they're so belittling and it's awful (Indiana).*

Indiana indicates a 'culture of bullying' as an explicit source of tension within the unit. In commenting that 'I just feel sick for that person' and 'it's awful', Indiana draws on a discourse of appal to signal her repulsion,



and, establishes her professional identity in opposition to the actions of this specific temporally based group of CCNs. Moreover, she notes her observations of the 'belittling' behaviour of 'certain group' and, staff being 'angry and in tears'. This example of horizontal violence is not an uncommon feature of participants' practice. It regularly manifests between CCNs, and this is discussed in further detail within the next chapter's focus on the role of in professional development in professional identity.

## **Conclusion**

This chapter analysed how intra-professional processes of collaboration, conflict and control within CCNs' practice contributes to professional identity constructions. The necessity of intra-professional collaboration for CCNs to complete a number of activities within their jurisdiction signals its value to CCN practice, however not all CCNs hold this perception. CCNs utilise specific meanings to negotiate boundaries of difference at the intra-professional level and these processes are contingently shaped by structural and organisational forces that include the spatial and temporal dimensions of CCNs' practice and the dominance of the medical profession. The four examples presented; preparation of medication, acute events, meal breaks and temporal boundary work demonstrate CCNs' need to collaborate. However, the power sharing that

characterises intra-professional collaboration stands in opposition to the autonomy promoted by nursing's professionalism.

The examples of CCNs' preparations of medication; acute events; meal breaks; and temporal boundary work reveal the influence of tempo-spatiality on CCNs' intra-professional collaboration. The spatial dimensions of the ICU challenge collaboration between CCNs, particularly when CCNs are confined to patient's rooms. As they must rely on assistance from other CCNs, the prioritisation of autonomy by some CCNs constrains the power sharing process of collaboration during the early shift. Moreover, spatiality exposes differential valuing such as accountability and responsibility within collaborative processes, and this results in overt processes of difference and conflict that can impact on professional identity construction.

CCNs share understandings of the temporal structures of their practice, and the interdependency that enables conformation to legislative requirements, including the checking of drugs, meeting required staff-patient ratios, and mandatory meal breaks. This common understanding is integral to the construction of difference between not only CCNs, but also

with other medical professionals. Temporality shapes CCNs' professional identities by structuring the fine grained rhythms that enable and constrain their practice and, by providing a point at which differences between participants can be constructed and negotiated. In performing temporal boundary work, participants construct differences in the practice of others across the boundaries separating the three nursing shifts. This indicates the presence of two distinct temporally-bound culture sharing groups of CCNs in the ICU, and this contributes to weakening the group cohesion necessary for professional identity.

This chapter's focus on intra-professional interactions suggests these processes as are salient as in informing professional identity as well as contributing to its ambiguity, as inter-professional processes. In the next chapter, the contribution of inter-professional boundary work is explored further through focusing on the salience of professional development to CCNs' professional identities.

## CHAPTER EIGHT

# Professional Development

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### **Introduction**

The previous two chapters focused on inter- and intra- professional interactions within participants' everyday practice. In doing so, they highlight how CCNs employ specific meanings attached to professional identity to construct difference between themselves, and to negotiate professional boundaries with other health workers. This chapter focuses on the contribution of professional development to CCNs' professional identities. I argue professional development is integral to professional identity, as it represents a point at which difference is constructed at the intra-professional level.

Theoretical and empirical literature observes professional development, in the form of on-going education, as central to nursing's professionalism and professional identity (Gallagher 2007; Gould, Drey and Berridge 2007). This is particularly the case in Australia, where mandatory continuing professional development (CPD) for nurses was introduced in 2010 (Ross, Barr and Stevens 2013:2). Given the importance of CPD, this chapter

explores its significance to participants' professional identities through three themes:

- Nursing's evolution as a profession;
- Education, training and support; and
- Role performance and promotion within the ICU.

Participants' perceptions of the importance of CPD vary; while some regard it as valuable, others observe an incompatibility between it, and their everyday CCN practice. While CDP often refers to formal educational courses, it additionally applies to on-going learning within the practice setting, however CCNs indicate this latter aspect is often not supported. Moreover, lack of organisational recognition and reward for postgraduate nursing accreditation raises questions of a mismatch between an ideology of professionalism, and its acceptance within wider society, which could negative influence CCNs' professional identities.

### **Nursing's evolution as a profession**

Nursing's evolution as a profession is readily identified by Grade 3 and Grade 4 CCNs. Grade 4 CCNs note the historic changes that have

influenced contemporary nursing practice, and its associated role with professional identity:

*The identity of the nurse has been studied for many years. And it's changed, their role; it's a different perception of what a nurse is, and it has changed for many years (Brenda).*

Brenda notes the difference between traditional, and, contemporary nursing identity. Her claim the 'identity of the nurse' and 'their role...has changed from many years', suggests a perception that such changes are associated with nursing's professionalisation. While there is no specific reference to nursing's professionalisation in the 1980's, the word 'different' and repetition of 'changed' appears to refer to this process. Furthermore, the declaration of 'the identity of the nurse has been studied', directs attention to one of the central features of contemporary nursing, namely the empirical focus that underpins the profession. This acts to contrast the contemporary nurses' identity, which is underpinned by an empirical evidence base, with the traditional nursing in which an empirical basis is lacking.

In contrast, Grade 3 CCNs tend to understand professional development as a necessary response to the on-going evolution of professional nursing, rather than in relation to historic changes. For example, the significance of

continuing professional development to the performance of the CCN role is revealed in the perception that:

*I do think it's very important that we do [engage in professional development]... because nursing's always progressing and how we do things change as well (Penny).*

What is notable about this explanation is utilisation of the word 'we', as it signifies a perception of being a member of a social collective, namely CCNs. This not only indicates that CCNs constitute a culture sharing group, but also the value they attach to professional development.

While the participants make little comment on CCNs' scope of practice as constitutive of role extension, my observations indicate that informants, particularly those employed as Grade 4s, regularly undertake role extension activities. An example is intravenous cannulation (Daffurn 1993). The following passage describes how this activity is negotiated between two Grade 4 CCNs (with Brenda in the role of CCNIC) and a Registrar during one late shift:

*Brenda tells the lounging Registrar 'we need you to put in a line; the patient only has one access line, and it's not looking good'. The Registrar sighs, 'When? Now?' He sees Airlee preparing for the task and asks, 'do you really need me?' Brenda snaps, 'well I thought since you're so busy...I suppose we can have a go'. Airlee hears this and looks to Brenda, 'can I?' Brenda shrugs; Airlee inserts the line (CCNA0704).*

The actions Brenda and Airlee suggest contradictory perceptions on performing work activities that are within the doctor's scope of practice, and an extension of the nursing role. These contradictions are seen to arise from the CCNs' interests being both '*common* and *very different*' (Strauss 1978:111, original emphasis). While the CCNs share the common goal completing the task of cannulation, they have distinct perspectives of practice. Airlee's actions can be seen as an indication that an extended scope of practice contributes to her job satisfaction (Strauss 1978). This suggests that CCNs maximise their opportunities to engage in activities associated with role extension (Carver 1998). This could be related to completion of postgraduate qualifications, which they perceive as enabling them to readily engage in such activities (Snelgrove and Hughes 2000). These explanations are only speculative, as Airlee's subsequent departure from the unit limited the generation of supporting data, however, her departure may be indicative of a lack of satisfaction within the ICU.

In contrast, Brenda's words, 'we need you to put in a line' and 'now' towards the doctor, convey a belief that cannulation is outside the CCN's scope of practice. This is strengthened by a resistance to direct the performance of the cannulation when the Registrar has refused to do so, and her indifference to Airlee's desire to complete the task.



These actions may reflect that her work satisfaction arises from exercising power over, and thus directing the activities of medical personnel.

What is evident in the above exchange between Brenda, Airlee and the Registrar are the underlying power dynamics between and within these professional groups. The CCNIC's challenging of the doctor signifies opposition to nursing staff undertaking clinical procedures outside their jurisdiction, particularly a mundane medical task that has been handed down despite a medical officer available. As such, this constitutes a rejection of professional identity as informed by a subordinate 'handmaiden' role (Carver 1998: 88). The Registrar's refusal to yield to the CCNIC represents a coercion into subordination (Strauss 1978), as there no other alternatives but to direct the CCN to extend her scope of practice. Despite their different perceptions, the CCNIC's use of 'we' to refer to herself and the other CCN is indicative of a perception of their membership of the same social collective and culture. The word 'we' is again characteristic of the 'us' and 'them' processes of boundary work discussed in preceding chapters. In this instance, Brenda's rhetoric serves to construct and bind the CCNs' social identity based on group similarity in opposition to that of the Registrar, as well as identify, define and reinforce the boundaries of the jurisdictions between the CCNs and medical practitioners.

## **Education, training and support**

Professional development is strongly associated with on-going education, particularly at the postgraduate level, and training and support of staff within the ICU. With the exception of three Grade 3 CCNs, all informants describe completing at least one postgraduate qualification, namely the Postgraduate Certificate of Critical Care Nursing (or equivalent), with two Grade 4 CCNs stating they additionally hold a Masters of Clinical Nursing, and one Grade 3 CCN holding a Postgraduate Diploma in Critical Care Nursing. The two Grade 3 CCNs who do not hold postgraduate qualifications express their desire to undertake further study in the near future (see Table 2: Sample characteristics on page 100 of Chapter Three).

The majority of Grade 4 CCNs praise their course content in furthering their nursing knowledge base. For example Indiana explains: 'I was really, really good at Bioscience, really good at nursing and yet when I did the [Postgraduate] Certificate I learnt a lot'. This reveals the dominance of medical knowledge within CCN practice and her Postgraduate studies. The claim of being 'really...good at bioscience [and] nursing' identifies not only her own competence, but also the scientific, or 'case knowledge' (as discussed in earlier chapters), as central to the nursing knowledge that informs her practice and professional identity. The utilisation of the words

'yet when I did the Certificate I learnt a lot', indicate that postgraduate education enabled not only a realisation of personal limitations of nursing knowledge, but also its broadening.

The realisation of one's own knowledge and practice limitation is evident when talking about initial perceptions of practicing in the ICU:

*ICU was a different, a different, place altogether. And I found it really confronting; being a year nine...registered nurse, like being very good at things...very good at what I do, like I had been...running wards... So I always felt I was good at what I did and then I went to ICU, and then suddenly ...I wasn't. I didn't know it all... It is confronting when you're not expert at what you do but I just persevered and decided ... I wanted to learn something different and do that [be an expert in CCN] (Indiana).*

This conveys a perception ('I felt') of practice capabilities ('very good') based on extended experience ('nine year') in areas outside the ICU ('wards'). This is contrasted with the 'different place' of the ICU and how this nursing environment challenged Indiana's skills ('I wasn't') and knowledge base ('I didn't know'). This idea of being challenged or limited is further emphasised with 'it is confronting when you're not an expert'. In stating that she 'persevered' to 'learn something different', Indiana alludes to postgraduate education, and thus awards value to the knowledge acquisition it represents as an element of her practice and professional identity as a CCN. Therefore, in this instance, professional identity seems to be constructed around the necessity of ongoing learning and education.

In contrast, a minority of Grade 4 CCNs critique the content of undergraduate and postgraduate courses with by stressing a lack of congruence between the content of the course and its application in their everyday nursing practice. These criticisms are voiced by the moderately experienced CCNs, such as Catrina:

*I didn't get...what I was hoping to...I was hoping to get... more of an understanding of critical care... things that you do, and monitoring, or machinery or...assessments. More of it was... how I did things in the unit. And then it was heavily based on your referencing...rather than them actually teaching you anything and then you go and relating back. It wasn't like... 'go and learn this, this and this 'cause this is how this works and then go and look after a patient and come back and do a report'. It was, 'what have you done lately that relates to these four topics, that's all you've got to choose from, and then write a report. So I didn't really get anything out of it learning, other than referencing (slight laugh), again' (Catrina).*

Catrina prioritises clinical and skill based, as opposed to knowledge and theoretical, nursing. This is notable as it is in opposition to the theoretical focus of nursing's education and its establishment within academe as a strategy of professionalisation (Grealish and Smale 2011). Moreover, it is interesting as contradictions within it reflect a sense of ambiguity. On the one hand, the importance of theoretical knowledge is signified in 'understanding... the things you do' and 'how things work', rather than simply mastering a clinical skill, which privileges theoretical knowledge. On the other hand, the expansion of clinical skill based knowledge of

‘understanding...monitoring...[and] machinery’ is prioritised through lamentation of the course’s focus on theoretical knowledge.

Catrina’s focus on technological aspects is of significance, as it reflects the centrality of machinery and technology to contemporary nursing practice more broadly, and within critical care nursing specifically (Almerud et al. 2008a; Almerud et al. 2008b; Barnard and Sandelowski 2001; Sandelowski 1997). The expression of dissatisfaction with a lack of technological and clinical skill knowledge within the course is highly suggestive of a process of difference in which there is identification with the clinical, rather than academic, spheres of nursing. This serves to construct CCNs as clinically based practitioners. This distinction between clinical and academic nurses draws attention to the possibility of the existence of disparate professional identities. When considered in regards to differing perceptions of the value awarded to the content of postgraduate qualification by more experienced and less experienced CCNs, the possibility of different culture sharing groups within nursing based on practitioners’ specific nursing context and length of practice is likely.

The notion of CCNs as a culture sharing group constructed around clinical practice, in opposition to nurses based in academe, is also acknowledged

by Hallam when he speaks with another CCN who was newly employed within the unit during an early shift:

*Hallam states, 'I think Bachelor of Nursing is a joke; there's a major difference between what they teach you on a theoretic level and what you actually do in clinical practice; there needs to be more focus on development of clinical skills, they need to be central to what you learn, rather than an add on to theory'. The CCN nods, 'I'd agree with that'. Hallam goes on, 'besides when was the last time anyone at the uni[versity] practised; I don't know how they keep their registration up; it makes you wonder about their clinical knowledge' (CCNH1502).*

Hallam's perception of 'development of clinical skills... [as] central' to nursing training demonstrates that, for him, that the performance of clinical tasks is key to his role and identity as a CCN. The construction of identity as a clinical nurse results from drawing differences and boundaries between himself and Nurse Educators. This is witnessed by his language of exclusion. In using the word 'they' to describe Nurse Educators, he constructs them as the 'other' (Jenkins 2000: 2014). He additionally promotes his own clinical abilities and inferiorises those of nursing academics through his construction of the latter as disconnected from ICU practice.

The moderately experienced Grade 4 CCNs' prioritisation of clinically based aspects of nursing at the expense of its theoretical underpinnings, is a concern shared by nursing researchers who highlight the existence of a

‘mismatch’ (Hamilton 2005; Maben, Latter and Macleod Clark 2006) or ‘gap’ (Grealish and Trevitt 2005; Porter and Ryan 1996), between the two. The CCNs’ identification of this gap is important. In valuing clinical, rather than theoretical knowledge, they perceive of nursing as a task-based activity, which aligns with the traditional structure of nursing. This contrasts contemporary nursing’s construction of theoretical knowledge as central to professionalisation. Thus, Catrina and Hallam construction as clinically focused nurses stand in contrast to the earlier example of the more experienced Grade 4 CCN Indiana, whose professional identity values the theoretical knowledge of postgraduate courses, and thus her ideas align more closely with those of contemporary nursing.

CCNs also construct themselves as clinical practitioners in boundary work that critiques the content of particular postgraduate courses, which serves to separate them from the managerial sphere of nursing practice. Donna talks about her Postgraduate Diploma: ‘I didn’t really like the course’, she pulls a face and shakes her head. ‘It’s all about managing people and I would rather look after patients than staff’ (CCND1005).

Donna refers to the content of her Graduate Diploma of Critical Care Nursing as focusing on the management of staff, and contrasts this with her preference to ‘look after patients’. She additionally utilises her body

language (pulling of face and shaking of head) to emphasise her aversion to performing managerial staff duties. This contrasts other CCNs, such as Indiana, who promote professional development as a way to support ICU and other hospital staff: 'You also need to be able to support. I think support is such an important thing; support and educate... supporting your staff...supporting everybody in the hospital really' (Indiana).

The reiteration of the word 'support' emphasises the high degree of value that she places on it in her practice. This indicates her professional identity is informed by supporting staff through the transmission of her knowledge within her everyday practice as a CCN. The supporting of staff that informs Indiana's professional identity is regarded as an asset in the leadership processes that are necessary to professional development (Fagerberg and Kihlgren 2001; Grealish and Trevitt 2005), and professional identity construction.

Brown, Stevens and Kermode (2012) identify three spheres in which support is central to professional identity processes in nursing. These include:

- professional role concept;



- acculturation; and
- acquisition of knowledge, skills, and professional values.

Observational data indicates that CCNs perceive the importance of these areas. This is most marked in their interactions with nursing students. For example:

*Airlee explains to her student 'it is important to keep an eye on her blood sugar; her swollen body indicates poor renal function'. She goes on to explain how 'renal dysfunction increases potassium in the patient and this in turn increases insulin uptake'. The student nods (CCNA702).*

<i>Gaynor:</i>	<i>So what are we measuring?</i>
<i>Student:</i>	<i>CVP</i>
<i>Gaynor:</i>	<i>Yes but what's that?</i>
<i>Student:</i>	<i>Central venous pressure; that's the pressure inside the central vein.</i>
<i>Gaynor:</i>	<i>Which of the lines and numbers on the monitor is the central venous pressure?</i>
<i>Student:</i>	<i>The white one.</i>
<i>Gaynor:</i>	<i>How do you know that?'</i>
<i>Student:</i>	<i>Two reasons; first because it is the same colour as the lumen that measures it and second is because it's the number closest to what I'd expect the reading to be.</i>
<i>Gaynor:</i>	<i>Okay. Now zero it.</i>
<i>The student looks confused.</i>	
<i>Gaynor:</i>	<i>Give it a flush; that's the same as zeroing it; you flush it to zero it (CCNG2003).</i>

In these interactions, the CCNs engage in leadership roles to promote the student's acquisition of knowledge and skills. Airlee transmits the theoretical and clinical knowledge (discussed in Chapter Four) to her

student, as she focuses on explaining the physiological underlying her concerns with her patient's 'blood sugar' while in 'renal failure'. In the case of Gaynor, she promotes these knowledges as well as the acquisition of technical knowledge (discussed in Chapter Four), as she challenges the student to explain and perform the routine task of measuring and zeroing her patient's Central Venous Pressure.

The transmission of the nursing knowledge underpinning nursing practice is indicative of leadership in CCNs' professional identities. This is further indicated in the CCNs' transmission of professional and organisational norms to students. For example:

*Catrina lounges in a chair chatting with three other CCNs on the OA when she looks out and sees her student at the bedside and calls to her.*

*Catrina: (first name) What are you doing?*

*Student: I'm looking after the patient.*

*Catrina: I know you're looking after the patient, but what are you doing. Right at this moment, what are you doing?*

*Student: Just looking at notes.*

*Catrina: You shouldn't feel like you have to be doing something all the time; sometimes things are quiet and the best thing to do is relax during that time (CCNC406).*

Catrina explains the accepted behaviour associated with working within the ICU to her nursing student in the presence of the other CCNs, including the CCNIC, while on a late shift. She conveys the normative expectations of the CCN role, including the acceptability of not 'doing

something all of the time'. Catrina supports the student's acculturation into the CCN role and practice within the organisation of the hospital.

Aside from the significance of support in the transmitting of nursing knowledges within CCNs' everyday practice, participants perceive that this also contributes to work satisfaction:

*Quite often it's a smooth shift; which is, we deal with whatever proverbial comes through the door, and we're all chipping in to help each other, and it's all good; it's a feral shift, but hey, nobody's dead, everybody's alive and everybody felt supported, we had a good shift (Gaynor).*

Gaynor's words 'deal with whatever proverbial comes through the door' on a 'feral shift' can be seen to reflect the indeterminant (Jamous and Peloille 1970) and stressful nature of CCN practice in managing unexpected events, such as new admissions and acute medical events. However, she observes that these are buffered by staff, 'all chipping into help each other'. In highlighting that 'everybody felt supported', Gaynor infers an awareness of inclusion, support, and empowerment (Hayes et al. 2012), as countering the challenging aspects of her practice and serving to increase her work satisfaction (Bartram, Joiner and Stanton 2004; O'Brien-Pallas et al. 2010; Sharbaugh 2009).

Yet Gaynor's choice of lexicon 'proverbial [and] feral' can also be interpreted to signify CCNs' social construction of patient types by which individuals are objectively categorised. This is supported in the following extracts from fieldnotes, where Catrina, Brenda and Indiana draw on the commonly utilised categories of 'sick' and 'not sick' to refer to patients, and Indiana elaborates on ward patients not really being sick. Catrina explains her two patients for the shift:

*They aren't too sick; they are really just ward patients that we've been keeping a bit of an eye on (CCNC0401)*

*Brenda talks about her patient, 'as you can see he's fine; except his output is down a little; he's not really sick'. She looks around the unit and comments, 'no one here really is [sick]'. She cups a hand over the side of her mouth and speaks in a low voice 'we [CCNs] like them to be sick; the sicker the better' (CCNB0804).*

*Indiana says 'sick [she holds her left hand palm up] means that a patient is at a high risk of deteriorating; there are little cues that we look for to indicate that the patient is becoming unstable'. She then gestures with her right hand in the same manner, 'not sick means that there is no underlying medical patho-physiology or infection' (CCNI1802).*

While the terms 'sick' and 'not sick' may appear neutral and objective classifications of patient's conditions, they are value laden terms related to patients' worthiness, of admission to the ICU and thus provision of their specialist practice. The reasoning behind Catrina's claim that her patients 'aren't too sick' lies in them being 'really just ward patients'. These words stand to clarify ('really'), reduce ('just'), and distinguish the acuteness of

the patients' condition to that of others outside the ICU (the wards). In Catrina saying 'we've been keeping an eye on' the patients, she further distinguishes these patients from those who require full application of her specialist nursing skills. The reduced value attached to less acute patients is conveyed in the final words of Brenda's comment, 'we like them to be sick; the sicker the better'. In referring to 'we', she indicates that CCNs as a collective possess common meanings of what 'sick' and 'not sick' signify. In addition, Brenda suggests sicker patients are not only worthy of the CCNs' specialist knowledge, but provide the CCNs an opportunity to apply this knowledge. The notion of categorising patients in this manner is striking when it comes to the classification of beds within the unit.

Indiana explains the bed categorisation:

*Indiana explains the way the beds in the ICU are allocated, 'we used to be an intensive and coronary care unit; we had 5 beds designated to cardiac patients ...but these have been moved to the new coronary care unit and now we have five beds for high dependency (HD) patients' (CCN1811a).*

The CCNs tend to devalue patients who are categorised as HD, as Gaynor does one night shift when she describes her patients:

*'These are both new admissions'. She turns back to look at the patient's in beds 8 and 9 and continues, 'these are HD patients, but they're in a bit of a pickle' (CCNG1203).*

Gaynor replicates the process of the earlier cited Catrina as she constructs boundaries of difference between the categories of the sick and deserving,

and the not sick and undeserving patients, within the unit. While she does not explicitly draw on the term 'sick' in the same manner as Catrina, Gaynor's utilisation of the word 'but' serves to heighten her previous comment that 'these are HD patients'. Her justification that these patients are 'in a pickle' serves to go beyond the general dismissal of HD patients within the unit, and thus Gaynor constructs them as deserving in this instance. The lower status of HD patients is also conveyed by Indiana:

*Indiana continues to talk about the five HD beds, 'now they're not specifically cardiac beds we get patients with anything and everything; ... they're drunks and retards'; she gives a dismissive wave ...and sighs, 'this means the HD beds are limited to people when they need them'... and it impacts on our staff allocation; we can't allocate senior staff members to nurse retards, so we try to only allocate the junior staff to those rooms, and that means they don't get the experience they should' (CCN1811b).*

In considering the theories of Goffman (1968) and Becker (1963), Indiana and the other CCNs differentiate between deserving and undeserving patients. This involves discriminatory and marginalisation process of stigmatisation and stereotyping. In choosing the words 'drunks' and 'retards' to refer to specific types of HD patients, Indiana applies a label that references particular social and physical characteristics that are negative and undesirable. The labelling and stigmatising of HD patients can have implications for the care they receive through less value being attached to their needs. Indiana's claim of, 'we can't allocate senior staff to nurse retards' is suggestive of a hierarchy of tasks within the unit, and

junior staff are allocated those activities considered to be beneath senior staff. Moreover, Indiana seems to view particular patients as placing limitations on resources within the unit, including the 'experience' that contributes to the professional development necessary to support professional identity processes of 'junior staff'. This interpretation corresponds to previous empirical evidence of medical staff's moral evaluation of patients through characterisation of unproblematic patients as 'good' in contrast to problematic, or patients considered to be deviant as 'rubbish' (Jeffery 1979: 92, 94)

While the majority of CCNs regard support as important in socialisation, professional development, and work satisfaction processes, the majority of participants consider a lack of support exists within the unit, including to allocated student nurses (Gaynor), and newly appointed CCNs (Nina):

*[A] new person needs all the help in the world...no one wants to go near [them]. And yet [they're] the one who needs more support than anyone else there...which is such a shame (Nina).*

*Gaynor calls to her nursing student and wags her finger towards the IV pole, 'I don't think you can use that line...that drug is not compatible with the one that's already running'. Gaynor moves to help the student and says in a low voice, 'I know there's others that like to sit in the OA and talk and let their students do everything'. She looks and nods towards a group of three CCNs (including an unidentified participant) lounging in chairs talking in the Observation Area and adds, 'I like to give my students a hand' (CCNG2010).*

In these extracts, CCNs from the most experienced (Gaynor) and less experienced (Nina) groups, share a perception of support as significant to professional development within nursing practice. This is achieved through an emphasis on the necessity of support for the 'new person' through repetition of the word 'need'. Gaynor utilises both physical and rhetorical strategies to underscore the differences between herself and other CCNs, and in doing so, the importance of supporting nursing students is conveyed. She draws on the actual act of supporting her student as a way of constructing difference between herself and the 'others [who] let their students do everything' that are sitting in the OA. In addition, she reinforces notions of difference between the two groups through language of inclusion and exclusion, evident in the word 'they' to describe the group as constituted by 'others'. In doing so, Gaynor separates herself as an exception to the culture of the ICU.

Indiana is another CCN in the most experienced group who is concerned with the lack of support and education within the unit:

*There's so many problems I guess... I guess the whole reason is that there's a few of us who are really passionate about doing what we do... we see it in a bigger perspective and we want to teach people and want to support the unit... We kind of have a different perspective (Indiana).*



Indiana, as noted in previous chapters, is a permanent member of night shift. Thus, her inclusion of collective pronouns ('us' and 'we') refer to a culture sharing group of CCNs based on temporality (Jenkins 2014; Zerubavel 1979a), who 'have a different perspective' towards education, support and professional development. This means that Indiana perceives other members of permanent night shift share the same values she attaches to support, education and professional development. Non-permanent night shift Brenda also notes a lack of support:

*If you've got the clinical ability, they [some senior CCNs] won't let you use it. 'Cause they don't want anyone else to have the power. And so they don't share knowledge 'cause that would mean... someone else would be on par (Brenda).*

Senior CCN Brenda constructs her identity with allusion to differences in support and resource sharing ('power' and 'knowledge') between herself and some senior CCNs ('they') within the unit. This reinforces the value of education and support as substantial facets of CCN practice, and the presence of another group of CCNs who exercise a competitive, rather than collaborative, form of power (Nungus et al. 2010). Moreover, Brenda's membership to temporal dimensions other than the night shift, would imply her claim relates to the autonomous group of CCNs established as temporally bound to the early shift (as noted in the previous chapter).

Indiana and Brenda assume a differential value attached to the resources of knowledge exchange, support and development of clinical ability, by a particular group of senior CCNs. Brenda's assertion 'they don't want anyone else to have the power', signifies that she associates this differentiation with the political processes within the unit (as identified in the previous chapter). In saying 'they won't let you use it' and 'they don't share knowledge', she alludes to limitation of resource access that she perceives as being central to the CCN role. These concerns are indicative of understanding resource access, including power and opportunities, as providing the empowerment necessary for the professional development of students and CCNs (Hayes et al. 2012). In observing a lack of access to resources, Brenda suggests disempowerment (identified within intra-professional processes in the previous chapter) impinges on positive socialisation and professional development, and ultimately, professional identity construction (Hayes et al. 2012). Participants acknowledge staff disempowerment within the unit and the associated negative consequences. This is expressed by Brenda and Karla:

*There's a particular group of people who bully the juniors and make them feel uncomfortable enough to leave the unit, and then they do it to the next lot that come along (CCNK1906).*

*All our new staff coming in are going to be traumatised, really; especially some of them. And even though you might help them a little bit, you can't help them all the time 'cause you're not there' (Brenda).*

In the above quotes, the CCNs describe their accounts of disempowerment of staff, particularly new appointees, within the unit. Disempowerment is suggested in Karla's direct reference to the bullying of newcomers and junior staff in the ICU by a particular group of senior staff. As discussed in the preceding chapter, bullying is the epitome of horizontal violence, and horizontal violence results in negative outcomes for victims, including feelings of loss of power, unease, anger and oppression (Purpora, Blegen and Stotts 2012; Vessey, Demarco and DiFazio 2010). Such negative feelings are suggested in the phrases 'make them feel uncomfortable', 'get eaten alive', 'angry and in tears', and 'traumatised', and thus, these passages offer further support for the incidence of horizontal violence discussed in the previous chapter.

These experiences are not specific to this ICU, but rather issues of bullying and horizontal violence that are common to the practice area. Vessey et al. (2009) suggest 18% of CCNs have experienced horizontal violence, and this figure is second only to 23% of nurses in medical and surgical nursing. While they do not explicitly identify CCNs as the source of bullying within the unit, Karla and Indiana's references to 'a particular group of people who bully the juniors' and 'senior staff' imply they are referring to senior CCNs. This aligns with empirical evidence that the most frequently

cited sources of bullying are senior nurses (24%), charge nurses (17%), nurse managers (13%) and other nurses (26%) (Vessey et al. 2009).

Furthermore, three of the Grade 4 CCNs unequivocally identify the victims as predominately junior nurses, as well as newcomers to the unit, and these are the same groups that report senior staff as perpetrators of bullying (Vessey et al. 2009). The three CCNs constitute the majority of Grade 4 CCNs who readily acknowledge the implications of horizontal violence on work satisfaction and CCN staffing levels within the unit. That staff are, 'angry and in tears', 'traumatised' and 'leave the unit', conveys notions of worker dissatisfaction and low retention rates that are closely associated with experiences of horizontal violence (Huntington et al. 2011; Twigg and McCullough 2014; Vessey, Demarco and DiFazio 2010).

CCNs observe how horizontal violence and lack of support within the unit can be exacerbated by a lack of strong leadership. This is expressed by the most experienced group of CCNs, including Brenda:

*They [management] haven't been involved with clinical for such a long time and it shows in the unit (laughs), because they don't want to be involved because it's too much to deal with...And they don't know they can't change it.... If there's a problem with someone or something, nothing's changed, nothing because our management doesn't like confrontation. So it's never going to be dealt with (Brenda).*

Brenda's concerns with 'management' within the unit draw on a discourse of challenge including the phrases, 'too much to deal with', and 'a problem with someone or something'. Her rhetoric of inclusion and exclusion, evident in the word 'they' as well as the phrases 'haven't been involved with clinical' and 'don't want to be involved', are suggestive of Brenda's understanding of management as a culture sharing group separate from the clinically based CCNs. Finally, Brenda conveys management's lack of leadership in addressing the issues within the unit in the phrases 'they don't know', 'doesn't like confrontation' and 'never going to be dealt with', which indicates that 'they' (management) do not understand the problem.

The perception of a work environment in which management lacks leadership qualities stands in contrast to arguments that emphasise strong leadership as a counter force in the prevention of horizontal violence (Longo and Sherman 2007; Randle, Stevenson and Grayling 2007). In management distancing themselves from the clinical practice of CCNs, they are unable to establish and encourage a common work culture in which the necessary resources for professional development, including support, education, and staff empowerment are promoted. This estrangement not only negatively influences positive professional identity construction, but also contributes to fragmentation. As a

result, the differences between CCNs further contribute to the ambiguity of nursing's professional identity.

### **Role performance and promotion**

All participants perceive professional development as a necessity for both promotion and the performance of associated senior roles, such as CCNIC and Access CCN, within the unit. Due to the restructuring of nursing employment levels within the hospital, however, there seems to be some confusion as to whether postgraduate qualifications are essential criteria for promotion. This is the case with less experienced Grade 3 CCN Nina, and the moderately experienced Grade 3 Marcus:

*It [promotion] can go by both [experience and education] as far as I'm aware of it... but don't quote me on that. You can do extra education and apply for; it used to be called Level 2 (Nina).*

*I don't think I'll get to the next level only by doing the course...[Postgraduate Certificate] I need to keep studying' (Marcus).*

This conveys the Grade 3 CCNs' sense of ambiguity in understanding the reorganisation of nursing employment levels within the hospital and 'what counts' in terms of distinction between themselves, the Grade 4 CCNs, and the management CCN roles of NUM (Nursing Unit Manager) and Nurse Educator. Nina's words 'as far as I'm aware' and 'don't quote me on that',

are telling of her confusion and lack of definitive understanding of the employment and promotion scale; she does not consider herself to be an expert on the topic. Marcus' concerns that the Postgraduate Certificate of Critical Care would not necessarily entitle him to promotion to the 'next level', suggests similar confusion about how the employment scale operates.

The CCNs' limited comprehension of the new nursing employment structure is evident in both Grade 3 and Grade 4 CCNs' answers to the question, 'What level are you employed at within the unit?'

*I'm a Grade 4, which is equivalent to the old Grade 2; I've been doing that for several years (Brenda).*

*Penny: A Grade 3, so a Level 1, yeah.  
MJB: And is that higher or lower than... a Level 2?  
Penny: Oh okay. Level 1, that's now changed to a Grade 3 which is just like most nurses are.  
MJB: So is Grade 3 higher or lower?  
Penny: Lower. Yeah lower.*

*MJB: So can you tell me what level of employment you work at in the ICU?  
Marcus: Ah Grade 3.  
MJB: Is that the old level 2?  
Marcus: Yeah yeah.*

Grade 4 CCN Brenda and Grade 3 CCN Penny epitomise participants' reference to their previous employment categorisations in relation to their current classifications. This suggests that such references inform their present position amid the ambiguity that has accompanied the employment restructure. Such references, however, do not alleviate the apparent confusion. For instance, Grade 4 CCN Brenda utilises the word 'grade' to describe both her current and previous employment classification. In contrast, Penny draws on Grade and Level to clarify between her previous classification of 'Level 1', with her current of 'Grade 3', and mimics the term 'Level' when prompted during her interview. Marcus equates his current 'Grade 3' with the previous Level 2 classification. The ambiguity of employment categorisation and associated criteria also extends to the performance of extended roles such as the In-charge or Access CCN. This is particularly the case with Grade 3 CCNs, including Nina:

*I don't know what's required to be an in-charge nurse...usually the Level 2s, and I say that like this because, I don't think it's called Level 2 anymore... I don't know what sort of training they've done to be the in-charge, but you can as a Grade 3, train to do the access position (Nina).*

The most experienced Grade 4 CCNs have clearer perceptions of not only the criteria of employment levels, but also of what these should be.

Indiana explains:



*I've got the Grad Dip now as well. Yeah, that's not been a requirement although I think for a Grade 5. It should be but I don't think Grade 5s are going to happen; I don't know what's happening with it, it's crazy (Indiana).*

Indiana's knowledge that the Postgraduate Diploma of Critical Care Nursing is not necessary to the appointment to 'a Grade 5' indicates her familiarity with the criteria of the higher Grade management level positions. Her assertion that the 'Grad Dip' should be a requirement for holding an upper level Grade 5 position demonstrates that she values postgraduate qualification and equates promotion as representing formal acknowledgement of qualification of academic training within the unit, and the hospital more broadly.

With that said, given that Indiana does not 'think Grade 5s are going to happen', it implicitly reveals a restriction within the new nursing career structuring. If Grade 5 positions have not been included in the restructure, as suggested in the previous passage, this would signify a serious limitation in the promotional processes of the unit, and the hospital more broadly. Furthermore, the absence of a Grade 5 classification for nurses seems to indicate a lack of formal recognition of postgraduate qualifications by the hospital in terms of increased remuneration, particularly at the Masters level. This practice is in stark contrast to the value of qualifications promoted within nursing academe, and individual

nurses' professional identity. In this way, hospital policy can undermine the professional identities and understandings of these for their staff.

Rather than the completion of postgraduate qualifications, promotion within the unit is based on CCNs' assumption of a portfolio. Grade 4 CCN

Karla explains the new promotion process and its associated criteria:

*What they [management] want to see...is you are someone who is help with junior staff, lead junior staff; that you are going to put a professional portfolio together, and be active in one of the National Competency Standards as well. So there's [sic] a number of things like pressure ulcer prevention, medication management, blood products... So it's moving forward... doing research, audits and stuff like that. So the new streamline process we need to pick a topic and then go from. So they're looking for leadership quality-wise as well there's a nice big section there where you have to give an example of where you've shown leadership' (Karla).*

Karla references 'help with junior staff', 'research', 'leadership' and 'Competency Standards' relate to dominant themes of continuing professional development. These include on-going education of self and transmission of knowledge to junior staff (Gallagher 2007), development of specialty specific competencies (Dunn et al. 2000), and leadership (Hughes 2005). This is significant because she highlights professional development as integral to the streamlined promotion process, and to her professional identity more broadly.

Grade 3 CCNs are generally supportive of the career restructure, however, this can be explained as arising from both their limited exposure to other ICUs and their lack of structural knowledge generally. This is in contrast to the most experienced Grade 4 CCNs, particularly those who had practised in ICUs outside Tasmania, who vocalise their disagreement about the promotion process within the current nursing career structure that privileges the ability to engage with a portfolio over postgraduate education. This is noted by two Grade 4 CCNs in the most experienced practice group:

*I've worked in many other units and so this one is a bit different... because other units have more... postgraduate levels. And your prestige-ness is based on your education level... as well as your clinical ability... But in this ICU there is a lot of prestigious alone without having any education basis; purely on the fact that some people have been there for a long time. Based on time rather than the education exposure or their own drive really. It's more because they've been there and seen... the unit does appear to...stand-alone compared to other ICU (Brenda).*

*It's a bit of a contentious issue because it's no longer a promotion to get to a Grade 4; it's time... I think it should be time in that area (sigh)... You need to have a lot of experience in ICU; you need to have your Certificate... so for me it's a bit of a contentious issue. I feel that a Grade 4 should still be a senior nurse in that area... Now the career structure has changed I'm not sure being a Grade 4 means anything really (Indiana).*

These CCNs engage in processes of difference that indicate their obvious disagreement with the current state of affairs regarding how appointments to Grade 4 positions are made within the unit. Brenda specifically contrasts

the prestige of CCNs in 'other units' on the basis of 'more postgraduate levels' against the prestige of CCNs in 'this ICU', which it is underpinned by 'time...rather than education'. She draws on a discourse of limitation (Norris 2001) evident in the words 'have more' in opposition to 'alone', to emphasise the limitations of CCNs within this ICU compared to the advanced educational level of others. This language highlights the importance that Brenda places on continuing education within the profession, and the problems associated with its devaluing within the career structure of the hospital and in the ICU particularly. The devaluing of postgraduate knowledge that Brenda refers to has implications for nursing's professional identity, as it conflicts with the ideology of nursing's professional status that informs CCNs professional identity.

Indiana's sigh, and accompanying repetition of the word 'contentious', similarly signify ambiguity through frustration at a career structure that appoints staff to an equivalent level as herself without their education or experience being equal to hers. Her words and actions also draw attention to the level of status attached to upper level CCN positions within the unit. Indiana's assertion that 'you need to have a lot of experience in ICU; you need to have your certificate' reflects the value she attaches to these resources. Her argument that Grade 4 CCN incumbents should be in

possession of postgraduate qualification and ICU practice experience signifies the position as one of status (Weber, Gerth and Mills 1946).

The status that Indiana attaches to a Grade 4 CCN can be understood as cultural capital. In this case, postgraduate qualification and previous ICU nursing experience represent the first of the two aspects of cultural capital; 'credentials...and preferences' (Lamont and Lareau 1988:155). These they are valued, and thus are legitimated within nursing and the ICU through the prestige that is awarded to higher level CCN positions. Indiana's understanding of the reduced value attached to the Grade 4 CCN role is conveyed in her final sentence: 'not sure being a Grade 4 means anything'. This captures a perception of the hospital's lack of recognition of CCNs' postgraduate qualification as a legitimate form of cultural capital despite its value within the discipline of nursing. It also denotes that the employment structure within the hospital conflicts with Indiana's own construction of professional identity in terms of the recognition of legitimate cultural capital, such as postgraduate qualification, informing promotion processes within the unit.

CCNs' promotion to Grade 4 without what is perceived to be the necessary cultural capital has practical implications in terms of the characteristic bureaucratic element of 'interchangability' (Weber, Gerth and Mills 1946; Zerubavel 1979a:111). Zerubavel (1979) points out that for an institution, such as a hospital, to fulfil its function of providing around the clock service, the 'interchangability' of staff across temporal dimensions is a necessary requirement. In the context of this study, the continual coverage of the ICU requires that any one CCN can perform a specific role within a specified grand scale temporal rhythm. For 'interchangability' of staff to be possible, nominated CCN roles, such as the Access CCN, require standardisation of accepted recruitment criteria and scope of practice. In the case of any one CCN holding a Grade 4 position without possession of established criteria, this would represent a lack of standardisation, and the inability of particular CCNs to fulfil the duties and responsibilities connected to the Grade 4 role.

Other CCNs also highlight the problematic nature of professional development and promotion within the unit. In the following excerpt, Fern discusses her postgraduate study in relation to her future promotion to an open Grade 4 position:

*I've completed the Grad Cert and Grad Dip; there's a new job going here and I've applied; it will be a promotion... I am the only female applicant. [She smirks and shakes her head] I don't think I'll get it; someone else will, one of the boys; that's the way of things here (CCNF2310).*

Fern highlights an obvious contradiction in her understanding of promotion within the ICU. On the one hand she alludes to her postgraduate qualifications, 'the Grad Cert and Grad Dip', in a manner that conveys her assumption they qualify her for promotion. On the other hand, Fern claims, 'I don't think I'll get it', despite having what she regards as the necessary qualifications. This apparent lack of optimism, as well as her references to 'being the only female applicant' and 'one of the boys', refers to the gendered nature of promotion within the unit. This highlights the contribution social capital makes over cultural capital in achieving the career success that informs professional identity.

In short, social capital refers to the capabilities of individuals to acquire gains due to their belonging to certain social networks or other social structures, such as gender (Portes 1998). In Fern pointing to male CCNs' promotion over female CCNs, she alludes to the contribution of social capital in male CCNs' promotion on the basis of her gender. This perception of male CCNs' social capital is also conveyed by Brenda and Indiana:

*I have been there for a while and I've seen a lot [of] the males seem to go to a higher level quicker than the females (Brenda).*

*I think you always had to have the Certificate...the only people who've ever got [to] Grade 4...without the Certificate here were boys (Indiana).*

Brenda and Indiana are drawing attention to what they perceive are the gendered dimensions of classification and promotion in nursing. Their words 'males... to go to a higher level quicker than the females' and 'the only people who've ever got ...[to] Grade 4...without the Certificate...were boys', directs attention to the differences between the promotion processes of female and male CCNs within the unit in a manner similar to Fern.

The perceptions of the three CCNs cited above are reflective of the gendered reality of nursing within Western health care systems in which male nurses both accelerate and secure higher level positions disproportionately to female nurses (Abrahamsen 2004). While male nurses constitute less than 10% of the overall nursing workforce (AIHW 2012b; WHO 2007), they hold between 8-10 percentage of senior positions (Evans 1997:226). Nina confirms this phenomenon within the unit and offers some explanations,



*Most of the males are senior nurses. I don't know if that's a reflection of less males going into nursing or it's [that] they're older nurses; they've just been there. I don't know if they're wanting to work their way to the top quickly type nurses. There are a couple of younger ones; one who is working up (Nina).*

Nina suggests two main reasons behind males holding a large percentage of Grade 4 CCN positions. Firstly, she highlights the logical association between 'less males' entering nursing and the retention rates of 'older (male) nurses' as contributing to the disproportionate level of male nurses achieving seniority. Secondly, Nina considers that male nurses may be 'wanting to work their way to the top quickly type nurses', and refers specifically to 'one who is working up'. Her employment of the word 'they' to reference the male CCNs suggests a process of difference whereby she estranges herself from them on the basis of gender, and the upward career mobility she perceives they possess. This reveals the gender politics of nursing extend to the ICU.

Theorists have long argued the workplace as structured along the same patriarchal dimensions as broader society (Crompton 1987; Game and Pringle 1983; Hochschild 2003; Witz 1992). This is particularly the case within health care delivery, where patriarchy is central to nursing's subordination to the dominance of medicine (Witz 1992). When

considering the disparate number of males in senior nursing positions, it can be explained through male domination promoted by patriarchy. This is particularly pertinent to the female dominated profession of nursing in which the securing of senior positions is undoubtedly associated with power over female subordinates.

The high number of male Grade 4 CCNs within the unit can also be explained using traditional notions of masculine and feminine gendered roles. Theoretically, the upward occupational mobility of males within nursing is underpinned by their commitment to fulfil the traditional masculine role of 'breadwinner' (Abrahamsen 2004). Male CCNs, informed by the breadwinner role, assume management roles due to the higher remuneration such roles offer, which allows for higher financial contributions to the families that they head. As such, male CCNs' upward mobility is explained by financial survival (Zysberg and Berry 2005). Moreover, the holding of a management position distances males from hands-on nursing practice and the constructed feminine characteristics of caring that are associated with it.

Aside from their predominance in management roles, male nurses enact masculine gender roles in their choices of the specific areas in which they practice. Markus explains his preference for critical care nursing:

*I like working with the machines and things. I like working in there [the ICU] based on the acuteness and the machines and things. Working in ICU uses more skills than working in the aged care, or somewhere (Marcus).*

Marcus' reasoning for choosing critical care nursing is evidently based on its 'acuteness', 'working with machines' and 'using more skills'. This resonates with the practice preferences of the majority of male nurses towards highly technological areas of Emergency Departments and Intensive Care units (Muldoon and Reilly 2003; Snyder and Green 2008) . These areas are seen as highly scientifically based and as such, align with the constructed masculine qualities of logic, rationality and objectivity. Such characteristics are in contrast to the constructed feminine qualities of emotionality, irrationally and subjectivity that are associated with the act of caring (Evans 1997; Muldoon and Reilly 2003; Zysberg and Berry 2005).

Marcus' attachment to the value of the supposedly masculine, technological aspect of nursing, rather than the constructed feminine components of nurturing would suggest different aspects of nursing inform gendered professional identities. This would indicate further

ambiguity of nursing's professional identity as argued in the three previous findings chapters.

## **Conclusion**

This chapter demonstrated how professional development is an integral aspect of CCNs' construction of professional identity. It contributes to the nursing knowledges that informs CCNs' actions, language and utilisation of artefacts within their everyday practice and represents a point of difference at which informants identify and reinforce boundaries between themselves. The transmission of nursing knowledge at the tertiary level is acknowledged as central to perceptions of professional identity, however CCNs value aspects of nursing knowledge differentially. While some CCNs privilege clinical knowledge to construct themselves as clinical nurses, they do so in opposition to nursing's professional focus on both theoretical knowledge and career development, and these contradictory perceptions can be seen to contribute to the ambiguity of nursing's professional identity. This lack of clarity is furthered by CCNs' differing perceptions of the importance of support and transmission of knowledge in its construction. While support and education were valued by most Grade 4 participants, they perceived a lack of support, evidenced by incidences of horizontal violence and lowered staff morale within the unit.

The ambiguity of professional identity is exacerbated by the influence of organisational factors, including the nursing career structure within the hospital. This is the cause of confusion among CCNs as to the criteria of their specific nursing roles and classifications, which ultimately weakens a clear notion of professional identity. This confusion is compounded when gendered differences are considered and results in tensions within the unit.

## CHAPTER NINE

# Discussion and Conclusion: Ambiguity overcome?

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### **Introduction**

In this final chapter, I elaborate on noteworthy features of the findings to directly address all three research questions. Specifically I deliberate on the provisional nature and ambiguity of CCNs' professional identities with a particular focus the conflict between objective, subjective and institutional understandings of nursing's professionalism. In doing so, the tensions of the contextual and contingent nature of CCNs' inter and intra-professional boundary work and how these shape their professional identities are considered. In addition, the influence of such strains upon CCNs' practice within the ICU is discussed. Further, questions of the strength of CCNs' shared meanings of professional identity as a single nursing specialty group, and what this means for nursing more broadly are raised.

This thesis revealed how CCNs participating in this study actively construct their professional identities through attachment of subjective

meanings and difference at the macro, meso and micro level. This includes boundary work between individual CCNs, the nursing profession, the employing organisation, other health workers, and CCNs and nurses outside the ICU. Throughout their practice, CCNs draw on shared knowledges to affix particular meanings to actions, language, rituals and the utilisation of artefacts, and these are significant to their professional identities. Participants employ these meanings to demarcate, reinforce and negotiate the professional jurisdictions that inform their identities. As these processes are influenced by organisational and structural forces operating within a hierarchy of knowledge inside the ICU, they contribute to a lack of clarity of the role that informs CCNs' professional identity constructions.

In discussing the implications of the findings, I acknowledge that although this study extends empirical and theoretical knowledge, it has been unable to completely remove the shroud of ambiguity surrounding nursing's professional identity. Rather, this thesis uncovers how CCNs' perceptions and performances of professional identity are shaped by historical, socio-cultural and political forces that are external to both nursing's professionalism and their everyday work context. These findings therefore, are not meant to be entirely conclusive. They specifically detail

CCNs' textured and multidimensional constructions of professional identity and the influence of interpersonal, organisational and structural forces on these processes that can inform future research directions.

### **CCNs' subjective understandings**

Professional identity reflects CCNs' nuanced experiences of being nurses and professionals within the field of the ICU. As is seen in Chapter Four 'The Multiple Constructions of Professional Identity', participants' professional identities are underpinned by subjective understandings that arise from within their own social contexts. These meanings are shaped by distinct social factors, including social positioning, choices to nurse, training environment, education level, years of practice experience, and everyday work context.

CCNs' diversity of meanings reflects theoretical and empirical work on professional identity, and support the personal, interpersonal and socio-historic dimensions proposed by Öhlén and Segesten (1998). Personal perspectives are evident in CCNs' self-evaluation of their personal characteristics as corresponding to those required for nursing practice. CCNs described professional identity as arising from pride and self-esteem in what they did for work. These typify psychological-based



approaches which relate professional identity to constructs such as self-concept, professional self-concept, and nurses' self-concept (Arthur 1992; Arthur and Randle 2007; Cowin 2001; Kelly and Courts 2007; Randle 2003b). As much of this approach has focused on defining and measuring psychometric properties of professional identity, this finding delivers new qualitative insights into what has generally been inconclusive, and theoretically based research.

CCNs' choices to nurse were not based upon a single definitive reasoning, but rather their motivations were guided by how they subjectively understood nursing from within their own social milieu. CCNs in the most experienced group were more likely to enter nursing on the basis of a vocational calling than those in the other two groups. While CCNs in the other groups spoke of caring, their reasons were underpinned by the ongoing career aspects nursing offered. As such, CCNs' choices to nurse were both expressive and instrumental, and this reflects those of contemporary nursing students (Eley et al. 2012; Grainger and Bolan 2006; Mooney, Glacken and O'Brien 2008; Somers, Finch and Birnbaum 2010; Zysberg and Berry 2005). Further, the differences between the most experienced and other CCNs also capture the changed role and identity of nursing as it transitioned from a vocation into a professional career.

That some, but not all CCNs indicated altruistic motives as central to their career choices resembles debates around the significance of altruism in contemporary nursing. Although motivations to nurse are still underpinned by the desire to care and traditional vocational calling (Eley et al. 2012; Fagermoen 1995; 1997; Mooney, Glacken and O'Brien 2008), nurses' comprehensions of these virtues are confused and contradictory, and this had led theorists to speculate a movement away from care as central to nursing's professional identity (Carter 2014; Cowin and Johnson 2011; Rognstad, Nortvedt and Aasland 2004). This conflation implies the close association between nursing's professionalism, professional identity and self-sacrifice is skewed, and its continual manifestation is a mechanism to safeguard the on-going existence of nursing ideology and practice, and ensuring control of workers (Evetts 2006; Haigh 2010).

The subjectivity of professional identity explains both CCNs' distinct meanings and their disagreement around specific occupational titles, and postgraduate accreditation that informs professional identity. Obvious contention surrounding self-identification with nursing generally, and the specialty of critical care nursing, demonstrates how meanings of professional identity are negotiated, rather than being tightly bound to particular objectively based social categorisations and accompanying accreditations. CCNs' divergence between the identities of Registered

Nurse and CCN however, reflects a weakness in shared collective identity as a single specialist group, and this challenges existing literature.

Bucher and Strauss (1961:326) conceptualisation of professions as a 'loose amalgamation of segments' bonded together by a collective title segments (or specialties) that are differentiated in their work tasks, approaches and methods as well as associated aims and ideologies. In applying this to CCNs, they are one of many specialty subcultures within nursing (Fitzgerald and Teal 2004; Mallidou et al. 2011). As nurses employed in specialty practice such as Mental Health, Child and Maternal Health, Community Health and Midwifery identify with their specialist role, rather than nursing more broadly, the finding that this cohort of CCNs did not, is exceptional (Belle and Willis 2013; Caldas Nicacio et al. 2016; Crawford, Brown and Majomi 2008; Drew 2011; Hurley and Lakeman 2011; Larsson, Aldegarmann and Aarts 2009; McCrae, Askey-Jones and Laker 2014). However, the findings of this study must be considered necessarily comparative to previous work that has generally focused on community, as opposed to acute, contexts of nursing practice. In order for such comparisons to be made, further ethnographic research of nurses practicing in other acute specialties is required.

## **The subjective/objective mismatch**

CCNs' subjective, on-going construction of professional identity within their everyday work environment is at odds with nursing's objective theorisation of its professionalism. While the professionalism of nursing is theoretically qualified on the historic significance of trait understandings of professions, these offer an ideal type of professional identity that is removed from the workplace context (Willettts and Clarke 2014). Viewing nursing's professionalism in this objective manner contributes to an ambiguity of professional identity as it detached from participants' everyday practice. This is seen in both Chapter Six 'CCNs' Knowledge and Inter-professional Interactions' and Chapter Seven 'CCNs' Intra-professional Interactions', where CCNs' experiences of professional identity are shaped by influences external to nursing.

That professional identity is shaped by organisational, structural and interpersonal influences is not a new finding, as such constraints are well acknowledged empirically. Canadian and British ethnographies have demonstrated time and space, as well as coherence between one's own, and others' perceptions of nursing are major challenges that nurses must negotiate within their practice (Allen 2002; Deppoliti 2008; MacIntosh 2003; Seneviratne, Mather and Then 2009). Moreover, in the Australian context, external influences often contribute to increased workloads,

particularly in the case of organisational restructuring (Duffield, Gardner and Catling-Paull 2008; Duffield et al. 2007; Lim, Bogossian and Ahern 2010). As such, my findings support previous results, as well as offering new insights on how external influences shape professional identity in the specific context of CCN practice.

For CCNs, disparity between macro-level objective theorisations of nursing's professionalism and their micro-level subjective experiences contribute to a conflation of meaning. While CCNs' multi-faceted perceptions of professional identity correspond to the multiple features identified and measured in comprehensive research of professional identity and the CCN role, their understandings are not necessarily coherent, and participants' multidimensional constructions exacerbate this confusion (Cook, Gilmer and Bess 2003; Cowin 2001; Cowin and Hengstberger-Sims 2006; Squires 2004). This lack of clarity in meaning furthers the argument that the ambiguity of professional identity arises from a disconnection between nursing theory and practice, commonly referred to as a 'theory practice gap' (Hamilton 2005; Maben, Latter and Macleod Clark 2006).

Empirical evidence indicates that the gap between theory and practice is closely connected to nursing curricula focusing on the holistic aspects of nursing theory without consideration of how organisational needs and values may dominate the workplace (Allen 2004; Arreciado Marañón and Isla Pera 2015; Hamilton 2005; Maben, Latter and Macleod Clark 2006).

While this study revealed how the theory-practice gap contributes to specific tensions in CCNs' practice and identity processes, research of other nursing specialties practice would be beneficial to extending knowledge on this topic further. Moreover, newly generated knowledge would contribute to studies of educational interventions and curricula changes to overcome this disconnect.

CCNs' confused and contradictory notions of professional identity, demonstrated in Chapter Four, 'Multiple Constructions of Professional Identity' are important in CCNs' constructions of similarity and difference with others. As there are divergent understandings of professional identity between CCNs, conflicts as to the most accepted constructions are bound to arise. This is evident in Chapter Seven, 'CCNs Intra-professional Interactions' where tensions between the ideal of autonomous practice as an aspect of professionalism, and the collaboration that characterises the environment of the ICU occur (Chaboyer and Patterson 2001; Rose 2011).

## **Collaboration, autonomy and power**

The findings illustrate collaboration within the ICU is central to participants' professional identities. As seen in Chapters Six and Seven, 'CCNs' Knowledges and Inter-professional Interactions' and 'CCNs' Intra-professional Interactions', collaboration is necessary to achieve both shared goal of optimum patient health in the ICU, and CCNs' completion of fundamental work activities within their jurisdiction. While this finding typifies previous research of ICU settings (Baggs and Ryan 1990; Chaboyer and Patterson 2001; Chaboyer, Najman and Dunn 2001b; Piquette, Reeves and LeBlanc 2009), it additionally provides new empirical knowledge of CCNs' intra- professional collaboration.

CCNs' intra-professional collaboration is comparable to previous theoretical and empirical findings of processes between health workers in differential roles. Research of collaboration has generally focused on inter-professional processes, and thus, application of ideas from that body of work provides new insight on intra-professional interactions. CCNs' intra-professional interactions exemplify theoretical literature and empirical studies' descriptions of collaboration as ownership and trade of resources such as knowledge, clinical skills, the bedspace, and the patient in 'co-operative ventures' where power is ideally distributed in relations of

‘sharing, partnership and interdependency’ (D'Amour et al. 2005:116; Kraus 1980:19; Lingard et al. 2004; Rose 2011). This knowledge contributes to a deeper understanding of interactions between CCNs which would inform future research of nurses working in other speciality areas, and this would accumulate further knowledge of both intra-professional collaboration and professional identity construction. Additionally, the application of findings from inter-professional processes has the ability to reveal and explain conflict between nurses.

The tensions between the primacy of collaborative practice in the ICU and the prioritisation of autonomy within the ideology of professionalism are demonstrated in Chapter Six, ‘CCNs’ Knowledges and Inter-professional Interactions’, Chapter Seven ‘CCNs’ Intra-professional Interactions’ and Chapter Eight, ‘Professional Development’. Such tensions align with conclusions of research into inter-professional research which conclude conflict arises from practitioners’ differential valuing of either autonomous ‘competitive’ or ‘collaborative power’ within their practice (Coombs and Ersser 2004; Nugus et al. 2010:902; Reeves and Lewin 2004a). This finding, if applied to studies that identify intra-professional conflict, such as the Australian work of Duddle and Boughton (2007), would



deliver further knowledge of the causes of conflict, and how it may shape professional identity construction.

CCNs' valuing of differential forms of power leads to conflict within the group as in-group differences are emphasised. This places strain on group solidarity and thus, impedes positive professional identity (Jenkins 2014). Such lack of group cohesion is evident in Chapter Seven 'CCNs' Intra-professional Interactions' and Chapter Eight, 'Professional development' where tensions between CCNs' manifests as anger, disempowerment and horizontal violence. These findings resemble reports of 'belittling and professional humiliation' that characterise horizontal violence, and result in victims' lowered self-esteem (Randle 2003a; Rayner 2002:399). Nursing literature in International and Australian contexts show horizontal, or lateral violence is widespread, and has a number of negative impacts, of which the most serious is low retention level (Chaboyer, Najman and Dunn 2001a; Edwards and O'Connell 2007; Embree and White 2010; Gilmour and Hamlin 2003; Hutchinson et al. 2006; Randle 2003a; Vessey, Demarco and DiFazio 2010).

As empirical evidence indicates higher incidence of horizontal violence and bullying within ICUs when compared to other nursing areas, my findings on this topic are not particularly surprising (Vessey et al. 2009). Further, the lack of strong leadership revealed in the findings is commonly identified as contributing to horizontal violence. This thesis shows CCNs' differential ideals of autonomy and collaboration underpin episodes of lateral violence within this ICU. This knowledge is foundational to extending qualitative research of both lateral violence and professional identity. This could focus on both processes as separate topics as well as associations between them, in other regional and metropolitan ICUs.

### **CCNs' Knowledges and boundary work**

Despite differences in understandings of professional identity, CCNs share ideas of the value of their expert nursing knowledges. These knowledges provide meaning to the actions, language, rituals and artefacts that inform CCNs' professional identities within their specialty practice. Although the importance of specific knowledges in constructing professional identity is well established within the sociology of professions (Abbott 1988; Gieryn 1983; 1999; Hughes 1963; Larson 1980; Turner 1987), the significance of this study's findings is the contextual

nature of CCNs' knowledges and how these are fundamental to both demarcation and diffusion of professional boundaries.

In Chapter Five, 'The Centrality of Knowledges' participants' knowledges are bound to the context of their specialised practice, and thus, at the core of their professional identities as CCNs. CCNs' knowledges manifest as in a language which is particular to the ICU, and this supports empirical findings of nurses using specialised language related to their context of practice (Thoroddsen, Ehnfors and Ehrenberg 2010). The findings additionally provide insights into the specifics of CCNs' vocabularies and thus, provide an opportunity for comparison of the work language of other nurses, and CCNs in other ICUs, to discover significant similarities and differences that would inform further research of professional identity.

CCNs' knowledges enable interaction between themselves, other health professionals, their patients and family. CCNs' 'unique position' (Svensson 1996:384) continually attending to patients enables gleaning of information that encompasses physical, psychological and social knowledges in a manner that is distinct from that of medical officers. However, as evidenced in Chapter Five, 'The Centrality of Knowledge' and Chapter Six, 'CCNs' Knowledges and Inter-professional Interactions',

CCNs' knowledges are positioned within a knowledge hierarchy where disparate value is awarded to particular aspects of CCNs' knowledges over others.

The differential value of nursing knowledges is highlighted in Chapter Six, 'CCNs' Knowledges and Inter-professional Interactions' where biomedical knowledge dominates interactions and nursing knowledges are often disregarded by doctors to exclude CCNs from inter-professional collaboration. This reflects the 'medical hegemony' previously identified within ICUs, and how it excludes nursing knowledge, and thus, establishes the boundaries between nursing and medicine's jurisdictions (Coombs and Ersser 2004; Manias and Street 2001a; 2001b). The devaluing of CCNs' knowledges also resembles Stein-Parbury and Liaschenko's analysis of the 'case' knowledge of biomedicine taking precedence over the 'patient' and 'person' aspects of nursing knowledges. In disregarding nursing's knowledges, nursing's claim to holistic-based professional knowledges as having equal standing to that of medicine is undermined.

However, it is evident that nursing knowledges are not always side-lined. My findings uncover CCNs proactively engaging in strategies to resist marginalisation and include nursing knowledges in decision-making

processes. This included 'being there, knowing the script, knowing what you want from the ward round silencing and gaze' previously identified within empirical literature (Hill 2003:231). Moreover, as seen in Chapter Four, 'Multiple Constructions of Professional Identities and Chapter Six, "CCNs' Knowledges and Inter-professional interactions', nursing knowledges are contingently acknowledged as complementary to that of biomedicine. This lack of consistency in the valuing of nursing knowledges is problematic for CCNs as such conditionality obscures professional boundaries, and in the process, confounds professional identity construction.

The ambiguity of professional identity is heightened by CCNs' valuing of particular forms of nursing knowledges and drawing on this in their boundary work with other CCNs. This is evident in Chapter Four 'Multiple Constructions of Professional Identity', and Chapter Five 'The Centrality of Knowledges' where CCNs construct differences between knowledges transmitted during hospital training, those transmitted through university education, and those gained through experiential practice.

Participants' acknowledgement of synthesis of scientific and holistic aspects within their knowledge bases as distinct from other health professions resonates with the literature (Svensson 2006; Yam 2004). Yet their prioritisation of practical and experiential knowledge at the expense of theoretical knowledge raises questions of the centrality of disciplinary knowledge to their professional identities. This is in line with conceptual analysis and empirical discoveries that point to understandings of professionalism on the basis of individual competence, clinical capabilities, and personal behaviours rather than macro-level ideologies of legitimate expert knowledge claims (Scott 2008; Shakespeare and Webb 2008; Svensson 2006).

Although CCNs' identification of instrumental and expressive aspects of their practice aligns with empirical evidence of the salience of both knowledges to professional identity, their advancing of one form over another is contradictory because both are equally valued within theoretical conceptualisations of nursing as an 'art and a science' (Mitchell and Cody 2002; Oldnall 1995). This paradox contributes to previous findings of nurses awarding differential value to either instrumental or expressive elements of their knowledges, dependent upon their practice context (Apesoa-Varano 2015; Charles-Jones, Latimer and May 2003; Fairley 2005; Hopkins and Irvine 2012; Snelgrove 2009; Woodward 1997).

The valuing of particular knowledges continues in Chapter Five, 'The Centrality of Knowledge' and Chapter Eight, 'Professional Development', where participants question and contradict the priority of theoretical knowledge within a clinical environment. CCNs' perceptions on the salience of theoretical knowledge to their professional identities differ, and thus, they reveal further lack of clarity in meaning. Yet participants' focus on clinical and technical knowledges rather than nursing theory, constructs their practice as an instrumental and task based activity. The prioritising of clinical and technical knowledges demonstrates these are fundamental elements in the distinct practice that informs CCNs' professional identities.

CCNs attaching higher value to clinical and technical, over theoretical knowledges is related to the highly acute and 'technologically intense' environment of their practice (Almerud et al. 2008b:131). This is seen in Chapter Five, 'The Centrality of Knowledges' where technical knowledges are revealed to be central to CCNs' understanding management, application and interpretation of technologies. Such a reliance on technology echoes qualitative work which found mastery of technology,

or what Little (2009:394) terms 'technological competence', is foundational to CCNs' learning and practice.

As CCN practice is highly technical, it is central to historical philosophical debates of the contradiction between the primacy of technology and the provision of holistic care within nursing (Barnard and Sandelowski 2001; Walters 1995). Yet, as seen in Chapter Four 'Multiple Constructions of Professional Identity' and Chapter Five 'The Centrality of Knowledges', participants negate these differences to construct professional identity by bridging the technical aspects of their practice with activities arising from the provision of holistic care. In Chapter Six, 'CCNs' Knowledges and Inter-professional Interactions' and Chapter Seven, 'CCNs' Intra-professional Interactions' participants' 'professional ownership of space between technology and the patient' positions them as a nexus between technical and holistic aspects of their practice, which is in line with theoretical propositions within nursing literature (Barnard and Sandelowski 2001:371).

CCNs' location enables them to mediate between not only technology and their patients, but also patients' families, other CCNs and other health



professionals. Thus, participants' negotiate the objective (technical) and subjective aspects of their practice to deliver care in the manner of empirical descriptions (Almerud et al. 2008a; 2008b; Barnard and Sandelowski 2001; Sandelowski 1997). As such, the findings support and extend theoretical and empirical knowledge of how CCNs in this study manage to overcome and merge two contrasting practice aspects to promote holistic care in the ICU. This can further contribute to comparative research of CCNs' practice and professional identities in other hospitals, and in international contexts.

Knowledges are not only a central element of CCNs' distinct nursing, but also constructions of professional identity as members of a culture sharing group. As seen in Chapter Five 'The Centrality of Knowledge', shared knowledges underpin CCNs' meaning-making within their practice, as their commonality includes and unites them as a group. Therefore, CCNs' knowledges are foundational to professional identity at individual and collective levels as they provide a boundary of difference between participants and other health professionals. Similar to CCNs' valuing of particular forms of nursing knowledges at the intra-professional level, others inside the ICU also award differential value to include and exclude CCNs and their knowledges.

Stuart Hall ([1996] 2000 :17) makes the point that ‘identities constructed through, not outside difference’, and it is the differences between CCNs’ knowledges, and those of other health professionals that are integral to professional identity. Yet, it is not only CCNs’ assumptions of difference that contributes to their individual and collective professional identity, but also those of others. As such, CCNs’ professional identities involve reciprocal construction of difference which corresponds to Jenkins’ (2000:8) theory of the ‘internal-external dialectic of identification’. This involves the construction of perceived similarities by one group (CCNs) and recognition and acceptance of difference by groups external to them (other health professions) in an on-going process of negotiation across professional boundaries.

## **Boundaries**

Participants’ expanded and extended role and knowledges have reshaped boundaries between the professions of medicine and nursing as aspects of the former have been incorporated into the jurisdiction of the latter. While CCNs draw on the distinctiveness of their knowledges in Chapter Five, ‘The Centrality of Knowledges’, to demarcate their jurisdiction, this is not

always the case. CCNs' jurisdictional boundaries and knowledges are not static, but rather they shift and 'blur' in response to contextual contingencies of practice (Harmer 2010:295; Nancarrow and Borthwick 2005; Tye and Ross 2000).

Throughout the findings, CCNs engage in activities of both axillary workers and medical professionals jurisdictions. For some CCNs', their extensive knowledges disqualifies their performance of low skilled tasks that have been 'passed down' to ward aides, whereas others happily perform technical duties once within the jurisdiction of medicine.

Alternatively, others refuse to perform tasks handed down from medicine despite being qualified by extensive theoretical and clinical knowledge-bases. This illustrates how CCNs' knowledges and practice are marginalised, accepted and exploited in response to organisational and structural dimensions of the ICU, and the hospital more broadly.

Nursing and sociological literature readily acknowledge the boundaries of nursing practice and professional identity are guided by organisational and structural influences. The temporal and spatial contingencies of CCNs' professional jurisdiction and thus, professional identities are evident in Chapter Six, 'CCNs Knowledges and Inter-professional

Interactions’ and Chapter Seven, CCNs’ Intra-professional Interactions’. In these Chapters, CCNs self –identify as members of a temporal bound culture sharing group as opposed to their profession, and the boundaries of their scope of practice is shaped by tempo-spatial and gender elements.

That organisation and structural forces contribute to blurring professional boundaries is apparent in qualitative research of hospitals, as well as generalist and specialist nurses’ practice (Allen 2002; Brooks and MacDonald 2000; Halford and Leonard 2003; Seneviratne, Mather and Then 2009). In addition, findings of studies making professional identity the research focus, emphasise the fluidity of professional boundaries confuses the jurisdictional edges of both generalist and specialty nursing roles (McCrae, Askey-Jones and Laker 2014; Pearcey 2008; Sayers et al. 2015). Empirical arguments that nurses are ‘boundary-spanners’, whose role is to mediate between the patient and the needs of health care organisations, is an evident aspect of CCNs’ practice (Allen 2004; 2014; Kilpatrick et al. 2012:1506). As there is a lack of clarity of boundaries in CCNs’ practice, uncertainty in the scope of role furthers the ambiguity of professional identity.

By uncovering a lack of clarity in the CCN role, this thesis extends empirical knowledge on ambiguity of specialty nursing roles which adds

to previous research findings of Nurse Educators, Mental Health Nurses and Community Nurses in Australian and International contexts (Bower, Jerrim and Gask 2004; Hercelinskyj et al. 2014; McCrae, Askey-Jones and Laker 2014; Sayers et al. 2015). These findings are also notable for making correlations between role ambiguities, lowered worker satisfaction and reduced retention rates which are common to my, and others' findings (Chen et al. 2007; Iliopoulou and While 2010; O'Brien-Pallas et al. 2010). Thus, research focusing on nursing in other areas with the aim of developing theoretically-based practical interventions to counter the negative implications of role ambiguity is necessary.

While CCNs are capable of crossing professional boundaries and practicing autonomously within medicine's jurisdiction, this cannot be interpreted as arising entirely from institutionally supported claims of nursing knowledges and jurisdiction. This is because members of the medical profession easily enable and constrain CCNs' autonomy. Rather it arises from 'workplace assimilation' whereby logistic practicality, organisational forces, gender and interpersonal factors, and the dominance of medicine is central to blurring and demarcating professional boundaries (Abbott 1988:65).

## **Medical Dominance**

The findings show how the shifting boundaries between nursing and medicine, and the collaborative environment of the ICU influence CCNs' interactions with doctors. These processes typify empirical and theoretical descriptions of inter-professional interactions, particularly 'the doctor-nurse game' of Stein and colleagues (1967; 1990:546). In some instances, CCNs subordinate directly to medical professionals, whereas in others they engage in covert decision-making to maintain the ultimate power of medicine. Additionally CCNs undertake informal and formal overt decision-making to negotiate the social order of the ICU at the patient's benefit (Porter 1991; Stein, Watts and Howell 1990; Svensson 1996; Sweet and Norman 1995).

As seen in Chapter Four 'Multiple Constructions of Professional Identity' and Chapter Six 'CCNs' Knowledges and Inter-professional Interactions', CCNs question doctors' authority to promote patients' agency. This finding adds to empirical evidence of nurses self-identifying as patient advocates to challenge doctors' judgements, and supports the priority of advocacy within nursing's professionalism (Grace 2001; Snelgrove and Hughes 2000; Water et al. 2016). Therefore, the boundaries between

medicine and nursing are not only demarcated by the power of the medical profession, but they are also reinforced by CCNs' resistance to subordination.

Although CCNs' initiation, control, and direction of doctors' interventions add support to medicine's deprofessionalisation, the findings contrast such a conclusion. Throughout the findings, medicine undoubtedly shapes CCNs' experiences of professional identity. As the profession of *par excellence*, medicine's unquestionable authority on all matters of health gives it direct control over the resources and activities of other workers in the sector (Freidson 1970a; Martimianakis, Maniate and Hodges 2009). This is clearly the case in Chapter Five 'The Centrality of Knowledges', and Chapter Six, 'CCN Knowledges and Inter-professional Interactions', where jurisdictional boundaries of medicine contour the borders of CCNs' professionalism as the former decides the limit of the latter's autonomous practice over their provision of holistic care, and CCNs accept the limits of their professional autonomy and ultimate accountability to medicine. The medical profession's dominance is further manifest in Chapter Seven, 'CCNs' Intra-professional Interactions' where CCNs' practice is both enabled and constrained by organisational recognition of the medical profession, and its knowledge as paramount.

CCNs' constant negotiation of jurisdictional boundaries contributes to the ambiguity of their professional identities. As professional identity is underpinned by notions of similarity and difference across professional jurisdictions, it is problematic for CCNs when medical knowledge is contingently valued over nursing knowledges. Likewise, CCNs' professional identities are challenged by the intersection of professional boundaries with tempo-spatial and gendered dimensions of practice, as these exacerbate the dynamism of boundaries of difference.

The blurring of jurisdictional boundaries between medical practitioners, CCNs, and Allied health professionals in ICUs is empirically common (Carmel 2006b; Coombs, Chaboyer and Sole 2007; Harris and Chaboyer 2002). Yet in Chapter Five, 'The Centrality of Knowledges' participants identify specific titles, namely CCNIC, Access CCN, Float and TPC to denote particular roles and responsibilities within inter-professional collaboration. While these role titles demarcate professional boundaries they provide little benefit in overcoming boundary burring, as their salience lies at the intra-professional, rather than inter-professional level.



## **CCNs' intra-professional boundary work**

CCNs' professional identities are further complicated by lack of recognition of nursing's professionalism by external groups and institutions. This includes medicine and other health professions, but more importantly, employing organisations and State-based health systems. Chapter Eight, 'Professional Development' shows how disparity between the valuing of postgraduate education within nursing's ideology of professionalism, and that assigned by the employing institution confounds CCNs' professional identities. Such lack of institutional recognition not only undermines nursing's professionalism at collective and individual levels, but in doing so, it negates any objective standard around which difference between CCNs' practice levels can be constructed.

CCNs disagree on what postgraduate accreditation should be standard qualification for higher level roles inside the ICU. These opposing views reflect wider debates of particular definitions, categorisations, scopes of practice and expanded, extended, specialist, and advanced nursing practice roles, particularly in the context of differences between Australian States and Territories (Elsom and Happell 2006; Lowe et al. 2012). That commonly accepted extended nursing roles titles, such as Clinical Nurse Consultant and Clinical Nurse Specialist do not exist in the fieldsite

demonstrates a lack of commonality between the hospital and the nursing organisations such as the Australian College of Nursing (ACN).

While the lack of standardised position titles contributes to confusion and tensions between CCNs, it should not be considered as exceptional.

Gardner et al. (2017) found sixty-six different nursing titles in an Australian survey which, when analysed, represented seven jurisdictions that corresponded to different nursing practice roles. This evidence strengthens claims of organisational and institutional negation of nursing's professionalism. Thus, it highlights that while nursing constructs professional identity on the basis of its professional ideology, this professionalism must be acknowledged and accepted by groups and institutions external to nursing in order for it to be legitimised (Abbott 1988; Hughes 1963; Jenkins 2014).

As CCNs' professional identities arise from on-going negotiations of similarity and difference, a lack of recognition of nursing's professionalism, disparity between objective, versus subjective practice experiences, and shifting jurisdictional boundaries pose a challenge to the shared meanings, and thus, solidity of CCNs as a culture sharing group. If meanings of professional identity are diffuse, CCN's ability, particularly

those who are new to the unit, to construct professional identity on the basis of similarity and difference becomes challenging.

Maxwell et al. (2013) found if the strength of CCNs' shared meanings of professional identity is questionable, negotiation of jurisdictional boundaries becomes problematic as group solidarity and cohesion is weakened. While moderate levels of cohesion between Australian nurses are evidenced empirically, the presence of adverse perceptions of group solidarity negatively impacts CCNs' work satisfaction levels (Chaboyer, Najman and Dunn 2001a; Kovner et al. 2006). As empirical work shows inverse relationships between strength of group cohesion, worker satisfaction and staff retention levels, the ambiguity of CCNs' meanings has the possibility to adversely affect the quality of care provision and staff safety within the unit.

## **Conclusion**

This thesis responded to the ambiguity surrounding nursing's professional identity. The central aim of the study was to explore how CCNs perceive and perform professional identity, the shared meanings of

CCNs' actions, language, artefacts and rituals that are significant to professional identity, and how CCNs draw on these meanings to negotiate professional boundaries with other health workers. The findings of this study demonstrate CCNs' professional identities are multi-faceted and are constructed through processes of difference between individual CCNs, other nurses (including CCNs), other health professions, the ideology of nursing's professionalism and health care institutions.

This thesis yielded some explanations of why nursing's professional identity lacks clarity however, the findings cannot be considered to provide a definitive meaning. CCNs' professional identities are their perceptions of being nurses and professionals however, these are shaped by subjective experiences in their socio-cultural contexts, and as such multifaceted meanings emerge. Such subjective experiences of professionalism oppose nursing's objective theorisation, and thus they contribute to an ambiguous understanding of professional identity.

An objective understanding of professionalism and professional identity neglects to consider how organisational and structural forces influence jurisdictional boundaries and knowledge valuing within everyday practice. Moreover, it denies the influence of organisational, structural and institutional forces on nurses' roles, practice and identities. This raises

questions of the overall strength of the professionalism that informs not only nursing's professional identity at the institutional level, but also at the level of individual practitioners. Moreover, the consequences of such uncertainties have the likelihood to reduce organisational recognition of nursing's expectations of its own professionalism. This can adversely impede on the working conditions, job satisfaction and retention levels of nurses, and this could ultimately place staff safety at risk, and more importantly lead to compromises in the quality of care provision.

The findings of this thesis indicate a number of possible opportunities for further research of nursing's professional identity. An interactional focus on professional identity within other nursing specialties could reveal aspects that are salient in its construction that are bound to contexts outside the ICU. As such, further qualitative research focussing on the boundary work that constitutes professional identities of nurses working in other specialties would yield further insight that may contribute to knowledge of subjective based understandings within specific practice areas, and these could inform nursing's professional identity generally. Alternately, placing nurses' intra-professional processes at the centre of research may uncover further distinctions in the meanings of professional identity between them, and offer new insights into how these are drawn on to demarcate and reinforce nursing's professional jurisdiction and the

tensions that arise from this which may promote or constrain positive identity construction.



## Appendix 1: INTERVIEW GUIDE

### **Interview guide: Professional identity construction by critical care nurses.**

This interview is about how you understand the term professional identity and what it means to be a critical care nurse. I want to know what you think about these things so that I can try and understand in the same way you do. In this interview you are the expert, so I want you to speak freely about what you feel is important and relevant.

#### **Introductory questions**

- Can you tell me about your nursing training and practice? (where, how came to be in ICU, other places worked, level of employment, years of experience, post graduate study)
- Are there certain shifts that you prefer to work over others?
- How often would you do, or make yourself available for overtime?

#### **Thematic questions:**

- 'Professional identity? (basis, features)
- Role as a critical care nurse? (Work activities, practices)
- Common ideas that critical nurses may share? (beliefs)
- Differences between working in ICU and on the wards?
- Gendered differences
- Good ICU nurse/Good doctor
- Collaborative/Autonomous practice.
- Equipment you work routinely work with (monitors, ventilator, dialysis)
- Advantages/disadvantages of working in critical care?





*Are you a Critical Care Nurse?*

My name is Melissa Belle and I am interested in understanding how you view your professional identity.

My research is being conducted as part of my PhD thesis. My supervisor is Dr Kristin Natalier, School of Social Sciences.

You are invited to participate in this study. Participation involves being observed while performing routine workplace activities at work and/or an interview lasting 60-90 minutes

*Interested?*

*Would you like some more information?*

Please contact me by telephone 6324 3657 or email ([mjbelle@postoffice.utas.edu.au](mailto:mjbelle@postoffice.utas.edu.au)), or Kristin Natalier ([Kristin.Natalier@utas.edu.au](mailto:Kristin.Natalier@utas.edu.au))

or phone: 6324 5045 )

## Appendix 3: PARTICIPANT INFORMATION SHEET

### **PARTICIPANT INFORMATION SHEET** **Tasmania Health and Medical Human Research Ethics Committee**

#### **RESEARCH PROJECT:** **Professional identity construction by Critical Care Nurses.**

##### **Invitation**

You are invited to participate in a research study exploring how Critical Care nurses construct their professional identity. This study is being conducted by Melissa-Jane Belle in partial fulfillment of her PhD studies at the University Of Tasmania, under the supervision of Dr. Kristin Natalier, senior lecturer at the School of Social Sciences at the University of Tasmania.

##### **What is the purpose of this study?**

The purpose of the study is to develop an understanding of how Critical Care nurses define their professional identity in their work.

##### **Why have I been invited to participate?**

You are eligible to participate in this study because of your position as a Critical Care Nurse. In this study we are exploring the professional identities of this type of specialist nurses. We are interested in how you understand, develop and experience professional identity in your work.

##### **What would my participation involve?**

If you agree to participate your everyday work activities would be observed. This would take place on a two-three hour basis, three to four days a week, for a minimum period of four weeks. Melissa-Jane will observe your use of routine equipment, interactions with patients, specialist nurses and other health professionals. These observations will be used to gain further knowledge of critical care nurses' understandings and experiences of professional identity at work. With your permission photographs of uniforms and routine work equipment will be taken but we will not capture any identifying features of your or anyone else (e.g. name badges, faces).

You will also be invited to participate in an hour to hour and a half interview with Melissa-Jane Belle at a mutually convenient time and location (this may be in a private office at your workplace or at the University of Tasmania). With your permission the interview will be audio-recorded for transcription. We will provide you with a transcription of your interview, and you can amend, clarify or retract the information they have provided. Interviews will include questions concerning

- demographic information (e.g. gender, age, occupational title and years of practice experience);
- your specialist nurse role and professional identity;
- your experiences working with other health professions
- language and tasks that are specific to your specialty
- 

**You are most welcome to agree to participate in one element of the study but not another element.**

**Will I be identifiable by being involved in this study?**

No. Your name and location of work will be assigned a pseudonym and these will be used in any publication arising out of the research. Pseudonyms will also be applied to your workmates and patients, as well as their friends and families. All information you provide will be anonymous and confidential. All electronic material (audio recordings, transcripts, observation notes and photographs) will be stored on a password protected computer, to which only the researchers have access. In keeping with University requirements this data will be kept by the University for five years after the completion of the study. After five years, the data will be erased.

**Are there any possible benefits from participation in this study?**

If we are able to take the findings of this study and link them with available literature on specialist nurses' professional identities, the result may be valuable information which would contribute to understanding how specialist nurses' professional identity is shaped by work context.

**Are there any possible risks or discomforts to me?**

Risks associated with participation are likely to be minimal. If there are questions that make you feel uncomfortable or which you do not wish to answer, you do not have to answer them. If you do not wish to be photographed, do not wish to be interviewed, or wish the interview to be recorded, you may refuse consent. If you wish me to stop observing you at any given time, or to stop completely, I will respect your wishes.

**Can I withdraw if I wish?**

It is important that you understand that your involvement in this study is entirely voluntary. While we would be pleased to have you participate, we respect your right to decline. Consenting to participant in observations does not mean you have to agree to be photographed, or participate in interviews. There will be no consequences to you if you decide not to participate. If you decide to discontinue participation at any time, you may do so without providing an explanation up until the publication of the thesis, due in July 2015.

**What if I have questions about this study?**

If you would like to discuss any aspect of this study please feel free to contact

Melissa-Jane Belle  
School of Social Sciences  
Telephone: 6324 3594  
Email: [Melissa.Belle@utas.edu.au](mailto:Melissa.Belle@utas.edu.au)  
[Krisitin.Natalier@utas.edu.au](mailto:Krisitin.Natalier@utas.edu.au)

OR

Dr. Kristin Natalier  
School of Social Sciences  
Telephone: 6324 5045  
Email:

**Has this research been approved by an ethics committee?**

This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email [human.ethics@utas.edu.au](mailto:human.ethics@utas.edu.au). The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number H0013483

**Thank you for taking the time to consider this study.**  
**If you wish to take part in it, please sign the attached consent from**  
**This information sheet is for you to keep**

## Appendix 4: CONSENT FORM

Phone (03) 6324 3946 Fax (03) 6324 3970  
Email Social.Sciences@utas.edu.au

SCHOOL OF SOCIAL SCIENCES  
Locked Bag 1340 Launceston  
Tasmania 7250 Australia



### PARTICIPANT CONSENT FORM

#### Professional identity construction by Critical Care Nurses

1. I have read and understood the Information Sheet provided to me for this study.
  2. The nature and possible effects of the study have been explained to me.
  3. I understand that the study involves:
    - Being observed performing routine work activities over a four week period for an approximate 3-4 hours per day during the months of November and December;
    - Being photographed with a digital camera while performing routine work activities (with my consent each time);
    - Participating in an interview of an estimated time of between 60 and 90 minutes which would cover the following topics:
      - Demographic information (age, gender, years of specialist practice);
      - Perceptions of specialist nurse role and professional identity;
      - Shared meanings and actions that inform professional identity;
      - Shared occupational boundaries between specialist nurses and other health professions;
- With my consent, the interview will be audio-recorded using digital recording equipment.
4. I have been advised of my right to:
    - Refuse to be photographed;
    - Choose not to answer individual questions or to terminate my participation at any time;
    - Refuse consent for the interview to be audio-recorded or request that the recording device be switched off.
  5. I understand that all research data will be securely stored on the University of Tasmania premises for five years from the publication of the study results, and will then be destroyed.
  6. Any questions that I have asked have been answered to my satisfaction.

7. I understand that the researcher(s) will maintain confidentiality and that any information I supply to the researcher(s) will be used only for the purposes of the research.
8. I understand that the research data gathered from me for the study may be published, and that I will never be identified by name or by other information in the thesis or any other publication arising from this research.
9. I understand that my participation is voluntary and that I may withdraw at any time without any effect and I may request that any data I have supplied be withdrawn from the research at any time up until the submission of the thesis (likely to be in July 2015). I understand that consenting to being observed does not mean I have to agree to being photographed, or participating in interviews.
10. I agree to participate in this **observation** of me within my place of work
11. I agree to participate in this **interview** and understand that I may withdraw consent at any time without effect or explanation
12. I agree for the interview to be **audio-recorded** using a digital audio-recorder and transcribed.
13. I agree to allow the researcher, Melissa-Jane Belle to **photograph** me in my workplace and for these photographs to be published without identifying features, subject to my approval of those photographs.

Participant's name:

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Participant's signature:

Date:

#### Statement by Researcher

☐

I have explained the project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐

The participant has received the Information Sheet where my details have been provided so participants have had the opportunity to contact me prior to consenting to participate in this project.

Investigator's name: Melissa-Jane Belle

Investigator's signature:

Date:





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